Clark, Charity

From: Cornell-Brown, Rowan
Sent: Wednesday, May 30, 2018 11:52 AM
To: Clark, Charity
Subject: VT charities using PFs
Attachments: Paid Fundraisers - Sorrell - 11-28-2016.pdf

I'm having a hard time tracking down the document I drafted last year. While I keep looking, here is the press release that went out in December 2016 (our latest public reporting of this data). At the time, only 11 Vermont charities used paid fundraisers. The current number is likely similar and certainly less than 20.

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STATE OF VERMONT
OFFICE OF THE ATTORNEY GENERAL
109 STATE STREET
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FOR IMMEDIATE RELEASE
November 28, 2016

Contact: William H. Sorrell
Attorney General

Todd Daloz
Assistant Attorney General

(802) 828-3171

GIVE WISELY: PAID FUNDRAISERS STILL ENJOY GREATEST BENEFIT FROM MANY CHARITABLE DONATIONS

As another holiday season arrives, Vermonters' generous spirits will be on full display, especially their charitable giving. But Vermonters should be careful. Many donations made through paid fundraisers—companies hired to solicit charitable donations—result in a fraction of the gift going to the chosen cause: only about 27% for gifts to Vermont-based charities in the latest fiscal year.

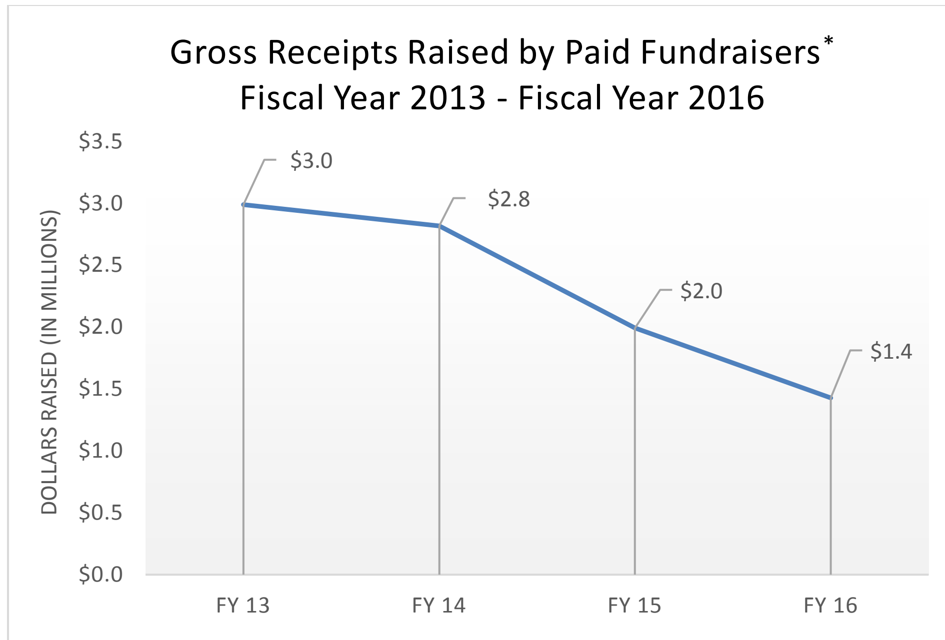
"This time of year, many of us look to help those in need or give to a favorite cause," said Vermont Attorney General Bill Sorrell. "Vermonters should remain aware that if their donations are made through a paid fundraiser, in most cases the bulk of that gift is going straight to the caller, not the charity. Just being aware of this can help folks make decisions that maximize the charitable impact of their dollars."

Based on data from the 255 reports filed for campaigns conducted between July 1, 2015, and June 30, 2016, paid fundraisers raised over $1.4 Million from Vermonters, but the named charities, both local and national, received only about $400,000. The 11 Vermont charities that used paid fundraisers during this time-period received only $195,993 of the $738,754 raised on their behalf – barely more than a quarter out of every dollar given:

Paid Fundraiser	Charity Name	Total Raised	Total to Charity	% to Charity	Goods/Svs Expenses	Net To PF
Aria Communications Corporation	Vermont Public Interest Research Group	$32,284.00	$2,782.42	8.62%	$0.00	$29,501.58
DialAmerica Marketing, Inc.	Special Olympics Vermont	$57,722.39	$6,658.28	11.54%	$0.00	$51,064.11
Harris Connect, LLC	Fletcher Allen Health Care, Inc. (Now UVM Medical Center)	$81,760.50	$12,369.24	15.13%	$0.00	$69,391.25
Front Line Support	Vermont Police Association	$81,787.00	$13,905.00	17.00%	$0.00	$67,882.00
Consult Tele Communications	Department of Vermont Veterans of Foreign Wars	$86,125.00	$18,948.00	22.00%	$47,369.00	$19,808.00
Police Publications, Inc.	Vermont Police Association	$58,832.00	$14,119.68	24.00%	$37,891.27	$6,821.05
TCI America, Inc.	Springfield Police Association	$16,156.00	$4,039.00	25.00%	$6,906.00	$5,211.00
Police Publications, Inc.	Vermont Trooper's Association	$124,048.50	$36,194.55	29.18%	$73,085.99	$14,767.96
Aria Communications Corporation	Vermont PBS	$33,905.35	$10,144.82	29.92%	$0.00	$23,760.53
TCI America, Inc.	Vermont Police Canine Association	$41,335.00	$12,401.00	30.00%	$15,603.00	$13,331.00
TCI America, Inc.	Rutland City Police Benevolent Association	$21,860.00	$8,088.20	37.00%	$7,206.00	$6,565.80
The Heritage Company, Inc.	Special Olympics Vermont	$90,741.60	$47,699.35	52.57%	$0.00	$43,042.25
Aria Communications Corporation	Planned Parenthood of Northern New England	$12,197.00	$8,643.18	70.86%	$0.00	$3,553.82
TOTALS		**$738,754.34**	**$195,992.72**	**26.53%**	**$188,061.26**	**$354,700.35**

Though six of these campaigns involved the sale of goods or services – e.g., magazines or concert tickets – the bottom line for the donor's dollar remains the same: in most cases, 30% or less of the total donation went to the charity for charitable purposes.

Paid fundraising activity in Vermont has diminished rapidly over the past three years. The $1.4 million raised from Vermont donors through paid fundraising campaigns in Fiscal Year 2016 represents over a 50% decrease from Fiscal Year 2013.



*Excluding Donor Advised Funds

"Vermonters should feel good about supporting the charities of their choice," Attorney General Sorrell said. "But information is vital whenever you hand over money, so be informed, and ask questions if you're not sure."

The Attorney General's Office urges Vermonters to:

- **Ask** all solicitors to explain **what portion** of a donation goes to support charitable programming and what portion goes to fundraising. Though paid fundraisers are not legally required to answer, they must tell prospective donors where to find such information (see next bullet).

- **Check the breakdown** of contributions between fundraisers and charities on the Attorney General's website: at http://ago.vermont.gov/focus/consumer-info/charities.php

- **Ensure** that those soliciting money over the phone, through mail, or via the internet **clearly identify themselves** and their employer.

- **Report any concerns** regarding paid fundraisers to the Vermont Attorney General's Consumer Assistance Program, 109 State Street, Montpelier, VT 05609-1001, or call (800) 649-2424; (802) 656-3183 within Chittenden County.

From:	Cornell-Brown, Rowan
To:	Clark, Charity
Subject:	RE: VT charities using PFs
Date:	Wednesday, May 30, 2018 11:59:39 AM
Attachments:	Draft press release 2017.docx

Found it! (speaking of naming conventions—I guess my calling it "Draft press release 2017" was a bad idea!)

In FY 2017, only *9* Vermont charities used paid fundraisers.

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FOR IMMEDIATE RELEASE
November XX, 2017

Contact: Thomas J. Donovan, Jr.
Attorney General
(802) 828-3173

GIVE WISELY: PAID FUNDRAISERS STILL ENJOY GREATEST BENEFIT FROM MANY CHARITABLE DONATIONS

As another holiday season arrives, Vermonters' generous spirits will be on full display, especially their charitable giving. But Vermonters should be careful. Many donations made through paid fundraisers—companies hired to solicit charitable donations—result in a fraction of the gift going to the chosen cause: only about 35% for gifts to Vermont-based charities in the latest fiscal year.

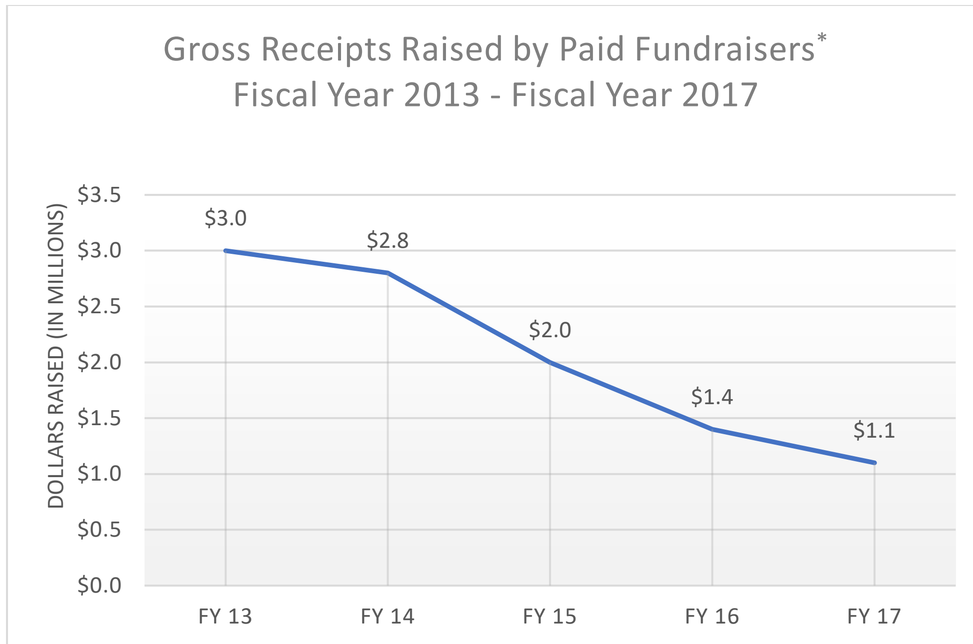
"This time of year, many of us look to help those in need or give to a favorite cause," said Vermont Attorney General T.J. Donovan. "Vermonters should remain aware that if their donations are made through a paid fundraiser, in most cases the bulk of that gift is going straight to the caller, not the charity. Just being aware of this can help folks make decisions that maximize the charitable impact of their dollars."

Based on data from the 230 reports filed for campaigns conducted between July 1, 2016, and June 30, 2017, paid fundraisers raised over $1.1 Million from Vermonters, but the named charities, both local and national, received only about $475,000. The 9 Vermont charities that raised money through paid fundraisers during this time-period received only $170,504 of the $485,381 raised on their behalf – about thirty-five cents out of every dollar given:

Paid Fundraiser	Charity Name	Total Raised	Total to Charity	% to Charity	Goods/Svs Expenses	Net To PF
Aria Communications Corporation	Vermont Public Interest Research Group	$15,265.00	$139.70	0.92%	$0.00	$15,125.30
DialAmerica Marketing, Inc.	Planned Parenthood of Northern New England	$3,695.00	$741.96	20.08%	$0.00	$2,953.04
Harris Connect, LLC	Department of Vermont Veterans of Foreign Wars	$90,901.00	$19,998.22	22.00%	$49,995.55	$20,907.23
Front Line Support	Vermont Troopers' Association, Inc.	$124,343.01	$36,584.03	29.42%	$81,979.17	$5,779.81
Consult Tele Communications	Vermont Police Canine Association	$19,738.00	$5,921.40	30.00%	$7,451.74	$6,364.86
Police Publications, Inc.	Rutland City Police Union Local 1201	$23,347.00	$7,704.51	33.00%	$8,809.49	$6,833.00
TCI America, Inc.	Vermont PBS	$15,201.91	$6,071.95	39.94%	$0.00	$9,129.96
Police Publications, Inc.	Special Olympics Vermont	$84,277.77	$34,264.08	40.66%	$37,518.84	$12,494.85
Aria Communications Corporation	Vermont Police Association	$108,612.00	$59,077.97	54.39%	$33,685.04	$15,848.99
TOTALS		**$485,380.69**	**$170,503.82**	**35.13%**	**$219,439.83**	**$95,437.04**

Though six of these campaigns involved the sale of goods or services – e.g., magazines or concert tickets – the bottom line for the donor’s dollar remains the same: in most cases, 30% or less of the total donation went to the charity for charitable purposes.

Paid fundraising activity in Vermont has been diminishing rapidly in recent years. The $1.1 million raised from Vermont donors through paid fundraising campaigns in Fiscal Year 2017 continues a four-year trend of decreased paid fundraising activity in Vermont.



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The Attorney General's Office urges Vermonters to:

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From: Diamond, Joshua
To: Clark, Charity
Subject: FW: Template Press Release for today"s filing in Texas v. HHS
Date: Thursday, June 7, 2018 7:32:13 PM
Attachments: [91] Response of Defendant Statest to Application for PI.pdf

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From: Joanne Adams <Joanne.Adams@doj.ca.gov>
Sent: Thursday, June 7, 2018 7:28 PM
Subject: RE: Template Press Release for today's filing in Texas v. HHS

Hello all,

My apologies for the delay, we just received a copy of the filing. Please see attached.

Please feel free to reach me by phone or email if you have any questions.

Thank you,

Joanne

From: Joanne Adams
Sent: Thursday, June 07, 2018 1:23 PM
Subject: Template Press Release for today's filing in Texas v. HHS

Hello all,

I hope this email finds you well. I am writing because your attorney general is joining our coalition opposing Texas' latest move to end the Affordable Care Act. I'm very sorry for the late email, below is a template press release for this afternoon's filing. I will circle back as soon as we have a final copy of the filing.

The embargo time for this press release is **4:00 PM (PT) / 7:00PM (ET).**

Please feel free to reach me by phone or email if you have any questions.

Thank you,

Joanne

Joanne Adams
Deputy Communications Director
Office of California Attorney General Xavier Becerra
916-210-6249

In *Texas v. HHS*, INSERT NAME Joins Coalition of 16 Attorneys General Opposing Texas' Latest Move to End the Affordable Care Act

SACRAMENTO – INSERT NAME today joined a coalition of 16 Attorneys General opposing a motion by the state of Texas and 18 other states in *Texas et al. v. United States et al.* seeking to halt operation of the Affordable Care Act (ACA) nationwide. The Texas-led lawsuit would end the ACA, threatening healthcare coverage for 20 million Americans – including nearly xx million in INSERT NAME – and divert billions of dollars in funding for critical healthcare programs and services nationwide. With his filing today, INSERT NAME continues his defense of the ACA. The coalition is led by Attorney General Xavier Becerra.

INSERT STATEMENT

The Texas lawsuit alleges that the individual mandate under the ACA is not constitutional. The coalition refutes this claim, noting that the ACA and its individual mandate have already survived review by the United States Supreme Court twice and over 70 unsuccessful repeal attempts in Congress, including the latest attempt in the Republican tax bill.

If successful, Texas' preliminary injunction would harm millions of Americans by:

- Stopping Medicaid expansion;
- Ending tax credits that help working families afford insurance;
- Allowing insurance companies to deny coverage to people with pre-existing conditions;
- Taking away seniors' prescription drug discounts; and
- Stripping funding from our nation's public health system, including work to combat the opioid epidemic.

In total, Americans living in the states that successfully intervened could lose half a trillion dollars in healthcare funding.

On February 28, 2018, Texas filed the lawsuit to dismantle the ACA in the United States District Court for the Northern District of Texas, Fort Worth Division and was joined by 19 other states. On April 9, 2018, Attorney General Becerra and 16 Attorneys General sought to intervene in the federal lawsuit to vigorously defend the ACA and the millions of families across the country who rely on it for affordable care. The motion to intervene was granted on May 16, 2018, and the coalition is now fighting for the ACA and opposing Texas' attempt to derail it.

Joining INSERT NAME in today's action are the Attorneys General of California, Connecticut, Delaware, Hawai'i, Illinois, Kentucky, Massachusetts, Minnesota by and through its Department of Commerce, New Jersey, New York, North Carolina, Oregon, Rhode Island, Vermont, Virginia, Washington, and the District of Columbia.

###

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, WISCONSIN, ALABAMA, ARKANSAS, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, PAUL LePAGE, Governor of Maine, Governor Phil Bryant of the State of MISSISSIPPI, MISSOURI, NEBRASKA, NORTH DAKOTA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, UTAH, WEST VIRGINIA, NEILL HURLEY, and JOHN NANTZ, Plaintiffs, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his Official Capacity as Acting COMMISSIONER OF INTERNAL REVENUE, Defendants.	Civil Action No. 4:18-cv-00167-O
CALIFORNIA, CONNECTICUT, DISTRICT OF COLUMBIA, DELAWARE, HAWAII, ILLINOIS, KENTUCKY, MASSACHUSETTS, MINNESOTA by and through its Department of Commerce, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA, and WASHINGTON, Intervenor-Defendants.	

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INTRODUCTION

Plaintiffs ask this Court to preliminarily enjoin the entire Patient Protection and Affordable Care Act (ACA), a landmark piece of legislation that has enabled more than 20 million Americans to gain health coverage, has restructured nearly one-fifth of the national economy, and has become central to the healthcare system of our country over the past eight years.[1] It is not an overstatement to say that issuing a preliminary injunction—which the Fifth Circuit has called an "extraordinary and drastic remedy"—would cause catastrophic harm to tens of millions of Americans. To date, over 11.8 million Americans have gained health insurance through the ACA's Medicaid expansion, another over 8 million receive ACA-funded tax credits to purchase health insurance through the newly-created exchanges, and 133 million Americans (including 17 million children) with preexisting health conditions cannot be discriminated against by insurance companies because of their poor health. There is no legal or equitable justification for depriving tens of millions of Americans of the benefits of these vital healthcare programs.

The remedy that Plaintiffs seek is also profoundly undemocratic. Plaintiffs ask this Court to impose an outcome by judicial fiat that Congress rejected through the legislative process. Since the ACA became law in 2010, ACA opponents in Congress have tried—unsuccessfully—to repeal it at least 70 times. But the fact that Congress (through the Senate) voted down each of those efforts leads to one unavoidable conclusion: the Congress that passed the ACA, the Congress that passed the Tax Cuts and Jobs Act (TCJA), and every Congress in between, has decided to leave nearly every provision of the ACA in place, choosing instead to modify one provision reducing the future tax penalty for individuals who do not maintain health insurance. That reflects the will of the

[1] Plaintiffs do not raise their Fifth and Tenth Amendment claims or their Administrative Procedures Act claims (Counts Two-Five in their Amended Complaint) as grounds for seeking a preliminary injunction. *See* ECF. No. 40. They have thus waived any reliance on those causes of action as a basis for the pending motion. *Jones v. Cain*, 600 F.3d 527, 541 (5th Cir. 2010).

people, as expressed through their democratically elected representatives over multiple election cycles.

And while courts are vested with the authority to interpret the Constitution and enforce its limits, they are not empowered to evaluate "the wisdom of the Affordable Care Act." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 588 (2012) (*NFIB*). "Under the Constitution, that judgment is reserved to the people." *Id.* Congress's repeated policy judgment against repeal makes sense given the Congressional Budget Office's (CBO) forecast that repeal would strip millions of Americans of their healthcare coverage, dramatically increase the federal deficit, and lead to Medicare Trust Fund insolvency. Aaron Dec. ¶¶ 43-44, Appx. 024-025; Corlette Dec. ¶¶ 53, 60, Appx. 100-104. And it is well-established that courts may not use their remedial powers to circumvent congressional intent, which is precisely what Plaintiffs are requesting.

Plaintiffs have not established any—let alone all—of the four prerequisites for obtaining the extraordinary relief that they seek. First, Plaintiffs are unlikely to succeed on the merits of their legal claims because the U.S. Constitution does not require a lawful tax to produce revenue at all times, and in any event, the ACA's "minimum essential coverage"[2] requirement will continue to produce revenue for years to come and therefore Plaintiffs' claims are not ripe. And if the Congress's recent amendment to the ACA were unconstitutional, the appropriate remedy would be to strike that amendment and revert back to the prior statutory provision which was upheld by the Supreme Court in *NFIB.*

Second, Plaintiffs cannot show irreparable harm. The individual Plaintiffs will not suffer any harm because it is perfectly lawful for them to pay a tax of $0 instead of obtaining ACA-compliant insurance. And the Plaintiff States cannot possibly be harmed

[2] For ease of reference, we refer to the "requirement to maintain minimum essential coverage" under 26 U.S.C. § 5000A as the "minimum coverage" requirement. This requirement is sometimes referred to as the "individual mandate," and the "shared responsibility payment" under this same provision as the "individual mandate penalty."

by the reduction of a tax that never applied to them in the first place. Third, any injury to Plaintiffs is far outweighed by the devastating harm to the Defendant States and their citizens from enjoining the ACA. The Defendant States stand to lose over half a trillion dollars in federal funds for healthcare, uncompensated care costs would rise by over a trillion dollars, six million of their residents would be kicked off of their Medicaid coverage, tens of billions of dollars in tax credits to subsidize purchasing health insurance would disappear, and millions of residents with preexisting health conditions would become unable to purchase or access health coverage. There would be an enormous human cost from invalidating the ACA. Lastly, a preliminary injunction would also disserve the public interest because it would upend the status quo and wreak havoc on the healthcare market for patients, providers, insurance carriers, and the federal and state governments. Plaintiffs' request for a preliminary injunction should be denied.

FACTUAL BACKGROUND

A. The ACA is Central to America's Healthcare System

1. The ACA increases access to affordable and quality healthcare.

The parties agree that the ACA is a landmark piece of legislation through which Congress sought to fundamentally transform the nation's healthcare system by increasing access to affordable, quality health care. Its purpose was to increase the number of Americans with health insurance, lower health insurance costs, and improve financial security and wellbeing for families. *NFIB*, 567 U.S. at 538; 42 U.S.C § 18091 (a)(2)(C), (F) & (G). Congress aimed to do so through a series of reforms, including strengthening consumer protections in the private insurance market, expanding the traditional Medicaid program, providing subsidies to lower premiums, and creating effective state health insurance Exchanges. *King v. Burwell*, 576 U.S. __, 135 S.Ct. 2480, 2482 (2015).

The ACA has delivered on these promises by making the individual insurance market more accessible and affordable; expanding and improving Medicaid; modifying and strengthening the Medicare program; increasing funding and prioritization of

prevention and public health; and supporting healthcare infrastructure such as community health centers and the National Health Service Corps. *See generally* Aaron Dec. ¶¶ 4-41, Appx. 003-023; Corlette Dec. ¶¶ 23-43, Appx. 092-098.

In the ACA, "Congress addressed the problem of those who [could] not obtain insurance coverage because of pre-existing conditions or other health issues." *NFIB*, 567 U.S. at 547. Congress placed new requirements on insurers that guarantee more affordable coverage regardless of health status, age, gender or geographic location. The ACA's "guaranteed-issue" and "community-rating" provisions bar insurers from denying coverage because of medical history and from charging unhealthy individuals higher premiums than healthy individuals. *NFIB*, 567 U.S. at 547-48. These two provisions are important ACA consumer protections. Sherman Dec. ¶¶ 3-4, Appx. 417-418; Aaron Dec. ¶¶ 48, 55, 62, 69, 76, 83, 90, 97, 104, 111, 118, 125, 132, 139, 146, 153, 160, Appx. 026-059.[3] And these provisions have given peace of mind to the millions of Americans with preexisting health conditions, while improving healthcare access for women, young adults, veterans, and persons with disabilities.[4] Aaron Dec. ¶¶ 13-16, 26, Appx. 008-016; Isasi Dec. ¶¶ 4-5, 12, 15, ECF No. 15-2 at 7-14; Berns Dec. ¶¶ 3-6, Appx. 077-079; Corlette Dec. ¶ 9-12, 15-16, 19, 20, Appx. 087-091.

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[3] Key protections of the ACA that would be impacted by the requested relief include (among others); guaranteed issue (42 U.S.C. § 300gg-1); guaranteed renewability (42 U.S.C. § 300gg-2); prohibition of preexisting condition exclusions (42 U.S.C. § 300gg-3); prohibition of discrimination based on health status (42 U.S.C. § 300gg-4); prohibition on excessive waiting periods (more than 90 days) (42 U.S.C. § 300gg-11); prohibition of lifetime or annual limits (42 U.S.C. § 300gg-11); prohibition on recessions once covered (42 U.S.C. § 300gg-12); coverage of preventative health services (42 U.S.C. § 300gg-13); extension of dependent coverage to 26 years of age (42 U.S.C. § 300gg-14); and the coverage of essential health benefits, including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse treatment, prescription drugs, laboratory services, preventative services and chronic disease management, and pediatric services, including oral and vision care. 42 U.S.C. § 18022.

[4] Examples of preexisting conditions include cancer, diabetes, asthma, heart attack and heart disease, stroke, high blood pressure, and pregnancy. *See* The Commonwealth Fund, "Access to Coverage and Care for People with Preexisting Conditions: How it Changed Under the ACA." Appx. 155-161.

As a result of the ACA's reforms, the rate of uninsured Americans dropped by 43 percent, resulting in 20 million Americans gaining access to health coverage because of this law. Aaron Dec. ¶ 5, Appx. 003; Barnes Dec. ¶ 4, Appx. 065-067; Corlette Dec. ¶ 28, Appx. 093; Gobeille Dec. ¶ 4, Appx. 109-110; Johnson Dec. ¶¶ 5-7. Appx. 116; Kent Dec. ¶ 3, Appx. 119-120; Lee Dec. ¶ 5, Appx. 131-132; Peterson Dec. ¶ 4, 6, Appx. 369-372; Mounts Dec. ¶¶ 7, 9, Appx. 144; Scholsberg Dec. ¶ 4, Appx. 375; Sherman Dec., ¶ 3, Appx. 417-418; Walker Dec. ¶ 5, Appx. 386-387; Zucker Dec. ¶ 5, Appx. 398-400; Allen ¶ 5, Appx. 411. Fewer uninsured individuals have helped healthcare providers and the Defendant States save money. The ACA lowered hospitals' costs of providing uncompensated care by $10.4 billion in 2015 alone; and in States that expanded Medicaid, uncompensated care costs dropped by around half. Aaron Dec. ¶ 10, Appx. 006; Corlette Dec. ¶ 34, Appx. 095; Eyles Dec. ¶ 9, ECF No. 15-1 at 96-97. As States have realized substantial budget savings accordingly. Aaron Dec. ¶¶ 11, 25, Appx. 006-016; Isasi Dec. ¶ 14 n.15, ECF No. 15-2 at 13-14; Mounts Dec. ¶¶ 14-17, Appx. 145; Barnes Dec. ¶ 5, Appx. 067; Gobeille Dec. ¶ 5, Appx. 111; Walker Dec. ¶ 6, Appx. 387; Shannon Dec. ¶ 7, Appx. 423-424; Schlosberg Dec. ¶ 5, Appx. 375-376; Zucker Dec. ¶ 6, Appx. 400-401; Johnson Dec. ¶ 10, Appx. 117; Kofman Dec. ¶ 5, Appx. 125-126; Allen ¶ 6, Appx. 411-412 Bohn ¶ 7, Appx 428. There are even documented ACA savings amongst the Plaintiff States, including Arkansas ($35.5 million in state fiscal year (SFY) 2014 and $131 million in SFY15) and West Virginia ($3.8 million in SFY14). Isasi Dec. ¶ 14, n.15 at 7 & 12, ECF No. 15-2 at 13-14.

And despite Plaintiffs' claims to the contrary, the ACA slowed the growth of insurance premiums in the group employer market. ECF No. 40 at 20 & 42. During the initial years of the ACA (from 2010 to 2016), employer-based health care premiums and out-of-pocket costs grew more slowly than they did in the 10 years before the ACA was enacted. Aaron Dec. ¶¶ 10, 19, Appx. 006-012; Corlette Dec. ¶¶ 42-43, Appx. 097-098.

The ACA also improved patients' quality of care. ACA reforms have developed care coordination, payment system efficiency, overall medical care quality, and consumer protections, leading to better health outcomes and delivery of care. Aaron Dec. ¶ 12, Appx. 007-008; Barnes ¶ 8, Appx. 72-74; Corlette Dec. ¶ 31, Appx. 094; Isasi Dec. ¶¶ 4, 17, ECF No. 15-2 at 7-8 & 15-16; Mounts Dec. ¶¶ 18-31, Appx. 145-148; Eyles Dec. ¶ 8, ECF No. 15-1 at 96; Kofman Dec. ¶ 6, Appx. 126-127; Allen ¶¶ 8-9, Appx. 412-415. ACA-authorized initiatives have enhanced quality of care by holding hospitals accountable for quality and safety (42 U.S.C. § 1395w–4, § 1395ww, § 1395f, § 1395cc); allowing providers to receive Medicare payments based on quality and care coordination (42 U.S.C. § 1395ww); and funding efforts to states, public health officials, educational institutions, and medical providers to improve treatment of chronic illnesses, reduce health disparities, improve efficiency and value, and to provide comprehensive care, including preventive care, and mental health and substance use disorder services (42 U.S.C. § 299b-33, § 299b-34, § 280h-5, § 280k, § 280k-1, § 280k-2, § 280k-3, § 1396a, § 300u-13, § 300u-14, 42 U.S.C. 294e-1). As a result of ACA reforms that improved the quality of care, fewer patients became sicker or died in the hospital due to hospital-acquired conditions in 2015 compared to 2010, saving approximately $28 billion in care costs over this period. Aaron Dec. ¶ 8, Appx. 005.

The ACA also provides new statutory authorization and funding for States to choose to participate in new and expanded programs that increase access to better-coordinated and high-quality care for low-income seniors and people with disabilities through federal programs, improve community health, and otherwise reduce healthcare spending. ACA § 2405, 42 U.S.C. §§ 300u–11, 300u–13, 300u–14, 1315a, and 1315b; *see also* Aaron Dec. ¶¶ 26, 27, 39, Appx. 016-022; Isasi Dec. ¶ 15, ECF No. 15-2 at 14; Berns Dec. ¶ 6, Appx. 079; Sherman Dec. ¶ 5, Appx. 419; Schlosberg Dec. ¶¶ 4, 7-8, Appx. 375-380; Peterson Dec. ¶ 7, Appx. 372; Lee Dec. ¶ 6, Appx. 132; Gobeille Dec.

¶¶ 6-7, Appx. 111-112; Barnes Dec. ¶¶ 6-7, Appx. 067-072; Zucker Dec. ¶¶ 7-9, Appx. 401-406; Walker Dec ¶ 7, Appx. 387; Mounts Dec. ¶ 6, Appx. 144.

2. Through the ACA's Medicaid expansion, States have provided coverage to millions of people and reduced healthcare costs.

The States are directly involved in implementing many of the ACA's policy reforms—particularly through its expansion of health coverage to lower-income residents. Aaron Dec. ¶¶ 21-26, Appx. 013-016; Boyle Dec. ¶¶ 4, 6, Appx. 082, 083. The ACA expanded Medicaid, which the States administer, making additional segments of the population eligible to receive coverage. *See* 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VIII), 1396a(e)(14)(I)(i) (childless adults with incomes of up to 138% of the federal poverty level may receive Medicaid). Nationwide, over 11.8 million newly qualified low-income individuals were receiving health coverage through Medicaid at the end of 2016 in the 33 states that have expanded Medicaid coverage, and the percentage of adults without insurance in those States dropped by 9.2 percentage points between 2014 and 2016. Isasi Dec. ¶¶ 7-8, ECF No. 15-2 at 10-11; Aaron Dec. ¶¶ 21-22, Appx. 013-014. Medicaid expansion allowed the Defendant States to provide healthcare for around six million low-income people. Aaron Dec. ¶¶ 85, 92, 106, 127, 134, 148, 155, 162, Appx. 037-059; Kent Dec. ¶ 3, Appx. 119-120; Barnes Dec. ¶ 4, Appx. 065-067; Walker Dec. ¶ 5, Appx. 386-387; Schlosberg Dec. ¶ 5, Appx. 375-376; Peterson Dec. ¶ 6, Appx. 370-372; Boyle Dec. ¶ 6, Appx. 083; Johnson Dec. ¶ 6, Appx. 116; Zucker Dec. ¶ 5, Appx. 398-400; Sherman Dec. ¶¶ 3-4, Appx. 417-418.[5]

Of the 33 states that expanded Medicaid through the ACA, seven are Plaintiffs in this litigation and represent 1,282,554 expansion enrollees, including: Arizona (109,723);

[5] The numbers are 3,700,000 in California, 240,000 in Connecticut, 11,000 in Delaware, 93,184 in the District of Columbia, 33,000 in Hawaii, 340,000 in Illinois, 151,000 in Kentucky, 350,000 in Massachusetts, 36,000 in Minnesota, 555,000 in New Jersey, 301,721 in New York, 159,000 in Oregon, 77,846 in Rhode Island, 3,000 in Vermont, 55,000 in Washington, 313,000 in North Carolina (estimated) if the state enacts an expansion, and 179,000 in Virginia when its expansion goes into effect. *Id.*

Arkansas (316,483); Indiana (278,610); Louisiana (376,668); North Dakota (19,965); and West Virginia (181,105). Eyles Dec. ¶ 6, ECF No. 15-1 at 95. Maine adopted Medicaid expansion through a ballot initiative in November 2017, but has not yet implemented it; however, state officials are under court order to begin implementation.[6]

States have benefitted from federal matching funds which incentivize States to expand Medicaid through the ACA. The ACA obligates the federal government to pay for all or almost all of the cost of this investment: 100% for years 2014-2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and beyond. *See* 42 U.S.C. § 1396d(y)(1). Based on the government's promise to pay the bulk of the costs, States invested over $4.28 billion to expand their Medicaid programs in fiscal year 2015, compared to the $68.8 billion expended by the federal government in matching funds.[7] Expansion states benefit from reduced spending on uncompensated care and additional revenue from insurer and/or provider taxes. Aaron Dec. ¶ 25, Appx. 015-016; Isasi Dec. ¶ 14, ECF No. 15-2 at 13-14. A recent study found no significant increase in state Medicaid spending, nor a decrease in education, transportation, or other state spending as a result of Medicaid expansion. Aaron Dec. ¶ 25, Appx. 015-016.

3. Federal subsidies and State-sponsored exchanges facilitate the purchase of healthcare.

The ACA also the authorized creation of state government-run health insurance marketplaces (also known as exchanges) that allow consumers "to compare and purchase insurance plans." *King*, 135 S.Ct. at 2485; *see also* Aaron Dec. ¶¶ 17-20, Appx. 010-013. Unlike the smaller, high-risk pools that some states operated before the ACA, access to

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[6] *See* Order on M.R. Civ. P. 80C Appeal of Agency Action, Business and Consumer Court Civil Action, Doc. No. BCD-AP-18-02. Appx. 163-175.

[7] Kaiser Family Foundation, "Medicaid Expansion Spending," FY 2015. Appx. 177-178. Spending in FY 2015 does not take into full account those states that expanded Medicaid after October 1, 2014, including Pennsylvania (expanded January 1, 2015), Indiana (expanded February 1, 2015), Alaska (expanded September 1, 2015), Montana (expanded January 1, 2016), and Louisiana (expanded July 1, 2016); Allen Dec. ¶ 4, Appx. 410.

ACA marketplace coverage is broad-based and affordable. Aaron Dec. ¶¶ 17-20, Appx. 010-013. "[S]tate high-risk pools covered only a fraction of people with preexisting conditions who lacked insurance, they charged significantly higher premiums than the individual market, and they excluded coverage for preexisting conditions for a period of time."[8] The ACA provides refundable tax credits to individuals with household incomes between 100 and 400 percent of the federal poverty line, but these tax credits can only be used in the marketplaces. *King*, 135 S.Ct. at 2487. States may establish their own exchanges, or use the federal government's exchange. *Id.* at 2485.

As of 2018, twelve States (including Defendants California, Connecticut, District of Columbia, Massachusetts, Minnesota, New York, Rhode Island, Vermont, and Washington) operate their own state-based exchanges, twenty-eight States rely on federally-facilitated exchanges, and eleven States partner with the Department of Health and Human Services to run hybrid exchanges (the latter two use HealthCare.Gov). Aaron Dec. ¶ 17, Appx. 010-011. States approve premium rates and review the plans to ensure that the cost and quality of benefits are reasonable and comply with state and federal law. *See* 42 U.S.C. §§ 300gg-94(a)(1), 18031(b)-(e); 45 C.F.R. §§ 154.200-154.230, 154.301, 155.1000-155.1010, 156.20, 156.200. Nationally, 10.3 million people obtained coverage through these exchanges in 2017, and 84 percent of this group—over 8 million people—receive ACA tax credits to help them pay for premiums. Aaron Dec. ¶ 18, Appx. 011; Isasi Dec. ¶ 6, ECF No. 15-2 at 10.[9]

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[8] Kaiser Family Foundation, "High-Risk Pools for Uninsurable Individuals," February 22, 2017. Appx. 180-190; *See also* White Dec. ¶¶ 1-9; Appx. 388-390.

[9] Exchange enrollment is 1,417,248 in California (as of March 2018), 98,260 in Connecticut, 24,171 in Delaware, 17,808 in the District of Columbia, 16,711 in Hawaii, 673,000 in Illinois, 71,585 in Kentucky, 242,221 in Massachusetts, 90,146 in Minnesota, 274,000 in New Jersey, 207,083 in New York, 519,803 in North Carolina, 137,305 in Oregon, 29,065 in Rhode Island, 29,088 in Vermont, 410,726 in Virginia, and 184,070 in Washington. Aaron Dec. ¶¶ 56, 63, 91, 98, 105, 119, 133, 140, 147, 161, Appx. 029-059; DeBenedetti Dec. ¶ 3, Appx. 106; Kofman Dec. ¶ 4, Appx. 124-125; Peterson Dec. ¶ 6, Appx. 370-372; Maley Dec. ¶ 8, Appx. 139; Johnson Dec. ¶ 7, Appx. 116; Wilson Dec. ¶ 3, Appx. 392-394; Lee Dec. ¶ 4, Appx. 131.

B. Preservation of the ACA is Necessary to Prevent Grievous Harm to the States and Their Residents

Eliminating the ACA would cause immediate and long-term harm to the Defendant States' healthcare systems and state budgets, and to their residents' health and financial security. Aaron Dec. ¶¶ 42-46, Appx. 023-026; Corlette Dec. ¶¶ 52-60, Appx. 100-104; Isasi Dec. ¶ 18; ECF No. 15-2 at 16; Eyles Dec. ¶ 12, ECF No. 15-1 at 98-99. The ACA is so interwoven into the health system that its elimination would damage Medicare, Medicaid, and other programs that pre-date—but were reformed by—the ACA. Aaron Dec. ¶¶ 42-43, Appx. 023-024; Corlette Dec. ¶ 60, Appx. 103-104. For example, Medicare probably could not make payments to Medicare Advantage plans because the ACA replaced the payment system; 19 million beneficiaries could lose their plans and publicly traded insurers' stocks could plummet. *Id.* at ¶ 42, Appx. 023-024. Public health programs, including those that help combat outbreaks and emerging public health threats such as the opioid epidemic, and which are now funded only through ACA programs, would likely cease to operate. *Id.*

Between 24 and 30 million Americans stand to lose their healthcare coverage, of whom the vast majority would be in working families.[10] Aaron Dec. ¶ 44, Appx. 024-025; Corlette Dec. ¶ 53, 55, Appx. 100, 101. Americans would face devastating losses in healthcare and financial stability gains attained under the ACA. Corlette Dec. ¶ 32-33, 59, Appx. 094-103; Isasi Dec. ¶¶ 5, 11, ECF No. 15-2 at 9; Eyles Dec. ¶ 8, ECF No. 15-1 at 96; Aaron Dec. ¶ 7, Appx. 004-005; Mounts Dec. ¶ 28, Appx. 147; Sherman Dec. ¶ 6, Appx. 419-420 (discussing less reported difficulty in paying medical bills); Schlosberg Dec. ¶ 6, Appx. 376-378; Zucker Dec. ¶ 10, Appx. 406-407. Smith Dec. ¶¶ 2-6, Appx. 382-383; Berns Dec. ¶¶ 4-5, Appx. 077-079; Gobeille Dec. ¶ 8, Appx. 112-113; Aaron Dec. ¶ 12, Appx. 007-008. Families with children born with conditions such as heart

[10] For example, an estimated 3 million New Yorkers will lose health coverage if the ACA is invalidated. Zucker Dec. ¶ 1; Appx. 395-397.

defects and diabetes would lose guaranteed access to coverage, and would face financial difficulties paying for life-saving care. Eilers Dec. ¶¶ 3-4, ECF No. 15-1 at 89; Lufkin Dec. ¶¶ 4-5, Appx. 135. Parents who leave the workplace in order to care for seriously ill children will once again fear loss of coverage, placing the health and financial stability of such families at risk. Chism Dec. ¶¶ 5-8, ECF No. 15-1 at 86-87.

The impact on the Defendant States would be profound and widespread. Aaron Dec. ¶¶ 42-165, Appx. 023-060. The loss of coverage by millions of Americans would lead to downstream costs to state-funded hospitals, which must provide emergency care regardless of insurance status or ability to pay. 42 U.S.C. § 1395dd. A dramatic increase in the number of uninsured would increase the cost of uncompensated care by an estimated $1.1 trillion over a decade, which would put stress on the financial market, state budgets and their healthcare systems, and medical providers. Aaron Dec. ¶¶ 44, 53, 60, 67, 74, 81, 88, 95, 102, 109, 116, 123, 130, 137, 144, 151, 158, 165, Appx. 024-060.

Most directly, Defendant States would collectively lose $608.5 billion dollars of anticipated federal funds used to provide healthcare to their residents, including: California $160.2 billion; Connecticut $14.8 billion; Delaware $3.6 billion; District of Columbia $1.7 billion; Hawaii $4.3 billion; Illinois $49.9 billion; Kentucky $ 49.7 billion; Massachusetts $22.5 billion; Minnesota $16.4 billion; New Jersey $59.7 billion; New York $57.2 billion; North Carolina $59.0 billion; Oregon $38.4 billion; Rhode Island $7.4 billion; Vermont $2.9 billion; Virginia $18 billion; and Washington $42.8 billion. Aaron Dec. ¶ 53, 60, 67, 74, 81, 88, 95, 102, 109, 116, 123, 130, 137, 144, 151, 158, 165, Appx. 028-060; Barnes ¶ 3, Appx. 64-65; Peterson ¶ 5, Appx. 370; Maley ¶ 7, Appx. 139; Kent Dec. ¶ 4, Appx. 120-121; Bohn ¶ 9, Appx. 429.

C. Courts Have Repeatedly Rejected Attempts to Strike Down the ACA

Since its adoption, the ACA has been the subject of intense litigation, including review by the United States Supreme Court twice. *NFIB*, 567 U.S. at 540-43; *King*, 135 S.Ct. at 2480 (upholding ACA authorization of tax credits for purchases on the federally-

facilitated exchange). The Supreme Court has rejected claims that would have gutted its key reforms (striking down only the mandatory component of Medicaid expansion) and provided lower courts ample guidance in resolving challenges to the ACA. In *King*, the high court concluded: "Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former and avoids the latter." 135 S.Ct. at 2496.

In *NFIB*, the Supreme Court provided similar guidance stating: "every reasonable construction must be resorted to, in order to save a statute from unconstitutionality." 567 U.S. at 521. The Court upheld the constitutionality of the minimum coverage provision,[11] concluding that Congress had the power to impose a tax on those without health insurance. *Id*. at 574-75. It also found that States could decide whether to participate in Medicaid expansion. *Id*. at 587, 645-646.[12] Since *NFIB*, numerous litigants have attempted to undermine the ACA's core provisions, but time and again, courts have rebuffed those efforts, avoiding a "calamitous result." *King*, 135 S. Ct. at 2496 (rejecting interpretation of ACA that would have "destroy[ed]" the health insurance markets created by the ACA); *see also e.g. Sissel v. U.S. Dep't of Health & Human Servs.*, 760 F.3d 1, 3 (D.C. Cir. 2014), *cert. denied* 136 S. Ct. 925 (2016) (rejecting claim that ACA violated the Constitution's Origination Clause); *Coons v. Lew*, 762 F.3d 891, 902 (9th Cir. 2014), as amended, (Sept. 2, 2014), *cert. denied*, __ U.S. ___, 135 S.Ct. 1699 (2015) (ACA preempted Arizona law that allowed citizens to avoid coverage and mandate penalties).

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[11] The minimum coverage requirement exempts certain individuals, such as prisoners and "individuals not lawfully present." 26 U.S.C. § 5000A(d).

[12] *NFIB* left untouched other ACA changes to Medicaid, such as a new mandatory eligibility category for former foster youth up to age 26, as well as a shift of children ages 6 and 18, with incomes beneath 133% of the federal poverty level, from CHIP to Medicaid. These provisions form a basis for the Plaintiffs' alleged "harm." Ghasemi Decl. ¶ 2, ECF No. 41 at 021.

D. Congress Declined to Repeal the ACA and It Remains Federal Law

Since its passage in 2010, Congress has voted on attempts to repeal the law an estimated 70 times, yet all such efforts have been voted down. *See, e.g.*, H.R. 3762, 114th Cong. (2015), H.R. 45, 113th Cong. (2013), H.R. 6079, 112th Cong. (2012).[13] In avoiding any repeal (partial or full), Congress has repeatedly made a policy judgment to avoid stripping millions of Americans of their federally-entitled healthcare coverage. Aaron Dec. ¶¶ 43-44, Appx. 024-025 (discussing 2015-2017 CBO reports finding that a partial or full repeal of the ACA would result in 24-29.8 million people becoming uninsured, an increase in the federal deficit, and lead to Medicare Trust Fund insolvency).

In December 2017, as part of an overall revision to federal income tax laws, Congress amended the tax code by reducing the shared responsibility payment to zero dollars for individuals failing to maintain health insurance coverage. *See* P.L. 115-97, 2017 H.R. 1, at *2092 (Dec. 22, 2017). By design, this change did not repeal any statutory provision of the ACA. *Id.* As Senator Pat Toomey (R-PA) emphasized, "We don't change any of the subsidies. They are all available to anyone who wants to participate. We don't change the rules. We don't change eligibility. We don't change anything else."[14] Additional floor debate prior to passage of the TCJA (as discussed further below) demonstrates a clear congressional intent to preserve the remainder of the ACA. Nevertheless, based on this single change, Plaintiffs ask this Court to strike down the entire ACA in direct contravention of Congress's stated intent.

LEGAL STANDARD

A preliminary injunction is an "extraordinary and drastic remedy, not granted routinely, but only when the movant, by a clear showing, carries the burden of

[13] For a list of efforts, see Cong. Research Serv., "Legislative Actions in the 112th, 113th, and 114th Congresses to Repeal, Defund, or Delay the Affordable Care Act," February 7, 2017, Appx. 192-219.

[14] 163 Cong. Rec. S7672 (daily ed. Dec. 1, 2017). https://www.congress.gov/crec/2017/12/01/CREC-2017-12-01-senate.pdf.

persuasion." *White v. Carlucci*, 862 F.2d 1209, 1211 (5th Cir. 1989). In the Fifth Circuit, the "four prerequisites for the extraordinary relief" of a preliminary injunction are: (1) a substantial likelihood that plaintiff will prevail on the merits; (2) a substantial threat that plaintiff will suffer irreparable injury if the injunction is not granted; (3) that the threatened injury to plaintiff outweighs the threatened harm the injunction may do to defendant; and (4) that granting the preliminary injunction will not disserve the public interest. *Canal Authority of State of Fla. v. Callaway*, 489 F.2d 567, 572 (5th Cir. 1974).

Relief should only be granted if the movant has clearly carried the burden of persuasion on all four requirements; failure to establish any element is grounds for denial. *Nichols v. Alcatel USA, Inc.,* 532 F.3d 364, 372 (5th Cir. 2008). The "decision to grant a preliminary injunction is treated as the exception rather than the rule." *Karaha Bodas Co. v. Negara*, 335 F.3d 357, 363-64 (5th Cir. 2003). Even when a plaintiff establishes each of the four elements, the decision remains discretionary with the district court. *Miss. Power & Light Co. v. United Gas Pipe Line Co*., 760 F.2d 618, 621 (5th Cir. 1985).

Plaintiffs carry an especially heavy burden when they seek a mandatory (as opposed to a prohibitory) injunction.[15] "Mandatory preliminary relief, which goes well beyond simply maintaining the status quo *pendente lite*, is particularly disfavored, and should not be issued unless the facts and law clearly favor the moving party." *Martinez v. Mathews*, 544 F.2d 1233, 1243 (5th Cir. 1976). Because "[a]n indispensable prerequisite to issuance of a preliminary injunction is prevention of irreparable injury, [o]nly in rare instances is the issuance of a mandatory preliminary injunction proper." *Tate v. American Tugs, Inc.*, 634 F.2d 869, 870 (5th Cir. 1981).

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[15] "[T]he issuance of a prohibitory injunction freezes the status quo, and is intended to preserve the relative positions of the parties until a trial on the merits can be held." *Wenner v. Texas Lottery Comm'n*, 123 F.3d 321, 326 (5th Cir. 1997).

SUMMARY OF ARGUMENT

The Court should deny Plaintiffs' request for a preliminary injunction because Plaintiffs have not established any—let alone all—of the four prerequisites for obtaining such extraordinary relief. First, Plaintiffs are unlikely to prevail on the merits. Continuous production of revenue is not a constitutional requirement for a tax, and the minimum coverage requirement will continue to produce revenue for years to come. If the Court nevertheless concludes that the minimum coverage requirement will become unconstitutional once it ceases to generate revenue, under long-standing and controlling Supreme Court precedent, the proper remedy is to strike the unconstitutional amendment and revert back to the prior statutory provision which was upheld in *NFIB*.

If the Court reaches the severability question, it should sever the unconstitutional provision and leave the remainder of the ACA intact, as the Supreme Court has done in almost every case over the past century. The touchstone for any decision about remedy is legislative intent, which a court cannot use its remedial powers to circumvent. Here, the Congress that passed the TCJA expressly and intentionally left the rest of the ACA untouched. Striking down the entire ACA would disregard that intent and impose an outcome that Congress chose not to achieve through the legislative process. Even if the severability inquiry turned on the intent of the Congress that enacted the ACA (and it does not), Plaintiffs have not come close to demonstrating that it is "evident" that Congress would have wished for the entire ACA to be struck down just because a later Congress reduced the tax for not maintaining health insurance to $0.

Second, Plaintiffs cannot demonstrate that they will suffer irreparable injury in the absence of injunctive relief. The individual Plaintiffs will suffer no harm whatsoever because it is perfectly lawful for them to pay a tax of $0 instead of obtaining ACA-compliant insurance. And because the shared responsibility payment does not apply to the States, they cannot possibly be harmed by its reduction.

Third, the alleged harm to Plaintiffs is far outweighed by the devastating harm to the Defendant States and their citizens that enjoining the ACA would cause. The Defendant States stand to lose over half a trillion dollars in federal funds for healthcare; six million of their residents would be kicked off of Medicaid; billions of dollars in tax credits to subsidize health insurance would disappear, and millions with preexisting health conditions would become unable to purchase affordable health insurance.

Fourth, a preliminary injunction is not in the public interest as it will inflict catastrophic harm on millions of Americans. The request is also a misuse of the preliminary injunction doctrine which is intended to preserve the status quo until the merits of a case are decided. Here, Plaintiffs do not seek to preserve the status quo, but to upend it. Their preferred remedy would uproot a complex and far-reaching law that has touched almost every facet of our healthcare system. Enjoining the ACA would completely disrupt the healthcare market at every level: for patients, providers, insurance carriers, and the federal and state governments. The application for a preliminary injunction should be denied.

ARGUMENT

I. THE MINIMUM COVERAGE PROVISION REMAINS A CONSTITUTIONALLY VALID EXERCISE OF CONGRESS'S TAXING POWER

Plaintiffs challenge the constitutionality of the minimum coverage provision once the shared responsibility payment is reduced to $0 in 2019. Specifically, Plaintiffs claim that the minimum coverage provision will exceed Congress's authority under the Taxation Clause because it will cease generating revenue for the federal government. For a number of reasons, Plaintiffs are mistaken. First, the minimum coverage provision still maintains the tax-like features identified in *NFIB*. Second, the production of revenue at all times is not a constitutional requirement for a lawful tax. Congress routinely enacts taxes with delayed effective dates, taxes that are suspended for periods of time, and otherwise structures taxes in ways which may not raise revenue for periods of time. The ACA itself includes several such taxes. Third, even if raising revenue at all times was an

ironclad constitutional requirement, the shared responsibility payment *will* continue to raise revenue for years to come because liability from 2018 is not due until April 2019, and many individuals pay their taxes late and the federal government will collect them through offsets years after they come due. Plaintiffs' claims are therefore not ripe.

A. The Minimum Coverage Provision Remains Constitutional

The minimum coverage provision continues to meet the *NFIB* factors and therefore remains constitutional. In *NFIB*, the Supreme Court explained that the shared responsibility payment "looks like" a tax in several respects. *NFIB*, 567 U.S. 563-64. First, the requirement to pay is found in the Internal Revenue Code and enforced by the IRS which must assess and collect it "in the same manner as taxes." *Id.* The payment is based on "such familiar factors as taxable income, number of dependents, and joint filing status." *Id.* at 563. Second, the shared responsibility payment produces "at least some revenue for the Government." *Id.* at 564. Third, the payment is a tax and not a penalty because the tax amount would be far less than the cost of purchasing health insurance for those who make the "financial decision" to pay rather than purchase coverage. *Id.* at 566. The Court thus concluded that because it had a "duty to construe a statute to save it, if fairly possible, that § 5000A can be interpreted as a tax." *Id.* at 574.

The fact that the shared responsibility payment raised revenue was just one of several factors that caused it to resemble a tax, and the generation of revenue was not central to the Court's constitutional determination. The Court noted that "[a]lthough the payment will raise considerable revenue, it is plainly designed to expand health insurance coverage," which is a perfectly valid exercise of Congress's taxing powers.[16] *NFIB*, 567

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[16] Although the Supreme Court noted that the "essential feature of any tax" was that it "produces at least some revenue for the Government," it did not hold that the ACA's shared responsibility provision *had* to raise revenue in order for it to be constitutional—much less that it had to raise revenue every year that the provision remains in effect. *NFIB*, 567 U.S. at 564-67. To the contrary, the Supreme Court concluded that the ACA's shared responsibility provision was a tax based on a coterie of other characteristics. *Id.*

U.S. at 567. In fact, if all non-exempt taxpayers made the "financial decision" to purchase insurance, the provision would not raise any revenue whatsoever. *Id*. at 566.

The shared responsibility payment continues to maintain these tax-like characteristics. Because only the dollar amount of the shared responsibility payment was changed (and could be changed again), its provisions are still contained within the Internal Revenue Code and tied to household income and filing status, and non-exempt households can continue to make a "financial decision" as to whether to purchase insurance coverage.[17] And as discussed below, the tax penalty will generate revenue beyond January 1, 2019, because this year's tax is not due until April 15, 2019, and the IRS can collect the tax for 2018 by way of offsets until all sums due are collected.

B. The Production of Revenue at All Times is Not a Constitutional Requirement for a Lawful Tax

The production of revenue at all times is a not a constitutional requirement for a tax to be lawful. Congress routinely enacts taxes with delayed effective dates and/or taxes that may not raise revenue in all calendar years, including numerous examples found in the ACA itself such as the so called "Cadillac Tax," the Medical Device Tax, and the Health Insurance Providers Tax. The shared responsibility payment has now joined that list of ACA taxes for which Congress has suspended collection, but retains the option of increasing in future years. The shared responsibility payment has not been rendered unconstitutional merely because it will be $0 in 2019.

Congress's authority to levy taxes is contained in the United States Constitution, which provides that "Congress shall have Power to lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare

[17] Although still a lawful tax, in the alternative, the minimum coverage provision may now be sustained under the Commerce Clause. In *NFIB*, the Court held that the minimum coverage provision exceeded Congress's Commerce Clause powers because it "compels individuals to *become* active in commerce by purchasing a product." *NFIB*, 567 U.S. at 552. But with a tax of zero dollars, there is no compulsion. The constitutional problem—*compelling* the purchase of insurance—is no longer present absent any penalty for failing to do so.

of the United States." U.S. Const. art I, § 8, cl. 1. These taxing and spending powers give the federal government "considerable influence even in areas where it cannot directly regulate." *NFIB*, 567 U.S. at 537. A tax does not cease to be valid because it discourages or deters the activities taxed. *United States v. Sanchez*, 340 U.S. 42, 44 (1950). A taxing statute is also valid "even though the revenue obtained is obviously negligible . . . or the revenue purpose of the tax may be secondary." *Id.* As the Fifth Circuit has stated, the "motives that move Congress to impose a tax are no concern of the courts . . . that an act accomplishes another purpose than raising revenue does not invalidate it." *United States v. Ross*, 458 F.2d 1144, 1145 (5th Cir. 1972).

In light of the broad taxing power afforded by the Constitution, it is not unusual for Congress to enact taxes with delayed effective dates or which are suspended for periods of time, including the shared responsibility payment that did not become effective until 2014. *NFIB*, 567 U.S. at 539. The ACA itself contains several examples of such taxes. The ACA's "Cadillac Tax" is a 40% excise tax on employer-sponsored healthcare coverage plans with premiums above specified thresholds. 26 U.S.C. § 4980I. When first enacted as part of the ACA, it had an effective date of 2013. Pub. L. No. 111-148, 124 Stat. 119 (2010). Since then, it has been amended three times to delay its start date.[18] In light of these delays, the "Cadillac Tax" has not yet raised any revenue, unlike the billions already generated by the shared responsibility payment.

The Medical Device Tax, which imposes a 2.3% excise tax on taxable medical devices, was enacted as part of Section 1405(c) of the Health Care and Education Reconciliation Act (HCERA) in 2010. Pub. L. No. 111-152, 124 Stat. 1029 (2010). It

[18] On March 30, 2010, Section 1401(b) of the HCERA changed the effective date of the tax to 2018. Pub. L. No. 111-152, 124 Stat. 1029 (2010). Section 101 of the Consolidated Appropriations Act of 2016, enacted December 18, 2015, further delayed the start date to 2020. Pub. L. No. 114-113, 129 Stat. 2242 (2016). And on January 22, 2018, Section 4002 of the continuing appropriations act pushed the effective date back to 2022. Pub. L. No. 115-120, H.R. 195 (2018).

was effective for sales after December 31, 2012, and was collected for calendar years 2013-2015. The Consolidated Appropriations Act of 2016 amended 26 U.S.C. § 4191 to impose a moratorium on the tax for sales between January 1, 2016 and December 31, 2017. Pub. L. No. 114-113, 129 Stat. 2242 (2015). This tax is again subject to a further moratorium through December 31, 2019 that is retroactive for sales after December 31, 2017. Pub. L. No. 115-120, H.R. 195 (2018). The Health Insurance Providers Tax was enacted as part of ACA Section 9010, and imposes an annual fee on large health insurance providers. Pub. L. No. 111-148, 124 Stat. 119 (2010). ACA Section 10905(f) made the tax effective for all premiums written after December 31, 2009. *Id*. Section 1406(a)(6) of the HCERA delayed the tax until 2014. Pub. L. No. 111-152, 124 Stat. 1029 (2010). The tax was collected from 2014-2016, then suspended for 2017. Pub. L. No. 114-113, 129 Stat. 2242 (2015). It will again be collected in 2018.[19] Most recently, this tax was suspended for 2019. Pub. L. No. 115-120, H.R. 190 (2018).

These ACA taxes demonstrate how Congress routinely suspends or delays impositions of taxes. By merely zeroing out the shared responsibility payment while leaving the minimum coverage provision in place, Congress intentionally left open the possibility that it will increase that tax in future years. With the stroke of a pen, Congress can increase the shared responsibility payment through the budget reconciliation process, just as it zeroed it out through that process. The fact that Congress reduced the shared responsibility payment to $0 commencing in 2019 is no different than these other ACA taxes which have not generated revenue each tax year since enactment. There is no constitutional infirmity here.

[19] Internal Revenue Serv., Affordable Care Act Provision 9010 - Health Insurance Providers Fee, (Rev. Mar. 2018). Appx. 221-227.

C. Plaintiffs' Claims Are Not Ripe Because the Shared Responsibility Payment Will Produce Revenue for Years to Come

Even if Plaintiffs were correct that a constitutionally-valid tax must produce revenue at all times, it will be years before the shared responsibility payment ceases to do so. Plaintiffs' claims are therefore not ripe. Since the shared responsibility payment is not decreased to zero until 2019, non-exempt taxpayers will still be liable for this penalty as part of taxes due on April 15, 2019. *See* 26 U.S.C. § 6072(a). The shared responsibility payment will yield revenue for the federal government in the range of $3 to $5 billion for 2018, based on the most recent data available.[20]

And much of that revenue will flow into the federal government's coffers after April 15, 2019. Like other taxes, the IRS may collect on any unpaid penalty from 2018 (or prior years) via offsets under 26 U.S.C. § 6402(a). And approximately 26% of individuals do not file their taxes on time, underreport their assets, or pay too little tax when they initially file.[21] Accordingly, the federal government will likely continue to collect shared responsibility payments owed from 2018 until 2020 or beyond. The shared responsibility payment will thus "produce at least some revenue for the Government" long after January 1, 2019. *NFIB*, 567 U.S. 564. Therefore, even if Plaintiffs' theory were legally sound, the Court could not enjoin the minimum coverage requirement until it ceased producing any revenue for the government several years down the road. Plaintiffs' claims are therefore not ripe, and this Court lacks jurisdiction to consider them.

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[20] In 2015, the last IRS reported year, the shared responsibility payment totaled $3.1 billion. *See* Internal Revenue Serv., U.S. Department of the Treasury, Pub. No. 1304, Individual Income Tax Returns 2015 26 (Rev. Sept. 2017). Appx. 229-230. And CBO estimates that amount will be around $5 billion in 2018. *See* Cong. Budget Off., Repealing the Individual Health Insurance Mandate: An Updated Estimate 2, Appx. 233.

[21] In 2016, the IRS reported that for tax years 2008-2010, the estimated voluntary compliance rate (VCR) of individual tax filers was 74%, reflecting a noncompliance rate (including nonfiling, underreporting, and underpayment) of approximately a quarter of taxpayers. Internal Revenue Serv., Research, U.S. Dep't of the Treasury, Pub. No. 1415, Federal Tax Compliance Research: Tax Gap Estimates for Tax Years 2008–2010 11 (2016), Appx. 254.

A plaintiff's standing to bring a cause of action is assessed at the time the suit was filed. *Davis v. FEC,* 554 U.S. 724, 734 (2008) ("While the proof required to establish standing increases as the suit proceeds…the standing inquiry remains focused on whether the party invoking jurisdiction had the requisite stake in the outcome when the suit was filed."). "A party facing prospective injury has standing to sue where the threatened injury is real, immediate, and direct." *Id.* But here, the government will earn revenue from the shared responsibility payment at least through 2019, and likely for years afterwards; therefore, any injury that might occur once the shared responsibility payment ceases producing any revenue is plainly not "real, immediate, and direct." *Id.* Plaintiffs' claims are not ripe, and the Court cannot consider them at this time. *Id.*

In sum, the shared responsibility payment remains a constitutionally valid exercise of Congress's taxing power, and this Court lacks jurisdiction to consider this challenge.

II. IF ZEROING OUT THE TAX MAKES THE MINIMUM COVERAGE REQUIREMENT UNCONSTITUTIONAL, THE REMEDY IS TO STRIKE THE RECENT AMENDMENT AND REINSTATE THE PRIOR TAX AMOUNT

If the Court nevertheless concludes that the ACA's minimum coverage requirement is unconstitutional once the tax penalty becomes $0 in 2019, the correct remedy is to declare only that amended provision unconstitutional. Under long-standing principles of statutory construction, when a legislature purports to amend an existing statute in a way that would render the statute (or part of the statute) unconstitutional, the *amendment* is void, and the statute continues to operate as it did before the invalid amendment was enacted. *See Frost v. Corp. Com. of Oklahoma*, 278 U.S. 515, 525-527 (1928) (holding that when a valid statute is amended and the amendment is unconstitutional, the amendment "is a nullity and, therefore, powerless to work any change in the existing statute, that [existing] statute must stand as the only valid expression of legislative intent"). The proper remedy is to strike the amendment that reduced the tax liability to $0 and revert back to the prior tax penalty found constitutional in *NFIB*.

In *Frost*, the Supreme Court ruled that an amendment to an Oklahoma licensing statute—passed ten years after the original statute was enacted—violated the Constitution's equal protection clause. *Frost*, 278 U.S. at 521-22. The Court then explained that the remedy for addressing an unconstitutional *amendment* to a statute was fundamentally different than the one used to cure an unconstitutional provision in the original statute. *Id*. at 525-26. If the licensing law "as originally passed had contained the proviso, the effect would be to render the entire section invalid." *Id*. at 525. However, "the proviso here in question was not in the original section" and "since the amendment is void for unconstitutionality, it cannot be given that effect, 'because an existing statute cannot be recalled or restricted by anything short of a constitutional enactment.'" *Id*. at 526 (citing *Davis v. Wallace*, 257 U.S. 478, 485 (1922)).

In other words, when "the statute, before the amendment, was entirely valid" and "a different Legislature" passes an unconstitutional amendment, that amendment "is a nullity and, therefore, *powerless to work any change in the existing statute*, that [existing] statute must stand as the only valid expression of the legislative intent." *Id*. at 526-27 (emphasis added). Under such circumstances—which mirror the situation here—only the recent amendment is invalidated and the statute reverts back to its original form. *Id*.

The courts have consistently applied this principle over the past century. *See, e.g., U.S. v. Tufti*, 542 F.2d 1046, 1047 (9th Cir. 1976) ("we applied the fundamental principle of statutory construction that a void act cannot operate to repeal a valid existing statute"); *Ross v. Goshi*, 351 F. Supp. 949, 954 (D. Hawaii 1972) ("it is a general rule of application that, where an act purporting to amend and re-enact an existing statute is void, the original statute remains in force); *Weissinger v. Boswell*, 330 F. Supp. 615, 625 (M.D. Ala. 1971) ("The elementary rule of statutory construction is without exception that a void act cannot operate to repeal a valid existing statute, and the law remains in full force and operation as if the repeal had never been attempted."); *State v. Standard Oil Co.*, 107

S.W.2d 550, 557 (Tex. 1937) ("[W]here an amendment to an act has been declared invalid, the original [a]ct remains in full force and effect").

In light of these authorities, even if the Court were to agree with Plaintiffs that the ACA's minimum coverage requirement—as amended by the TCJA—becomes unconstitutional because it will cease raising revenue at some point in the future, and that Plaintiffs' contentions are ripe for resolution, the proper response is to strike down the unconstitutional amendment. *Frost*, 278 U.S. at 526-27. And the previous tax penalty—passed years earlier by a prior Congress and upheld by the Supreme Court—"must stand as the only valid expression of legislative intent." *Id.* at 527.

III. EVEN IF THE MINIMUM COVERAGE REQUIREMENT IS NOW UNCONSTITUTIONAL, THE REST OF THE ACA IS SEVERABLE

For the reasons outlined above, the Court should conclude that the ACA's minimum coverage requirement, even with a $0 tax penalty beginning next year, is fully constitutional. And if not, the remedy is to strike down the recent amendment and reinstate the prior payment. But even if Plaintiffs could overcome these significant hurdles, they still cannot meet their heavy burden of demonstrating that the entire ACA should be struck down because a single provision is unconstitutional. The ACA's many goals are still advanced even without the minimum coverage requirement.

Plaintiffs have not identified a single instance—and Intervenor-Defendants are not aware of one—in which the Supreme Court has struck down the entirety of a federal statute with the breadth and scope of the ACA based on a *single* provision being unconstitutional. The ACA contains 10 titles, stretches over 900 pages, contains hundreds of provisions, and has been the law for over eight years. *NFIB*, 567 U.S. at 538-39. Striking down the entire statute, including hundreds of perfectly lawful provisions—most of which have nothing to do with the individual insurance market—would be an extraordinary result. As the Eleventh Circuit explained when it declined to invalidate the entire ACA, "in the overwhelming majority of cases, the Supreme Court

has opted to sever the constitutionally defective provision from the remainder of the statute." *Florida ex rel. Atty. Gen. v. U.S. Dep't of Health and Human Services*, 648 F.3d 1235, 1320-21 (11th Cir. 2011) (holding that the minimum coverage requirement was unconstitutional but could be severed from the rest of the ACA), *reversed in part by NFIB*, 567 U.S. 519 (holding that the minimum coverage requirement was a constitutionally valid tax and therefore not addressing its severability from the rest of the ACA). The result that Plaintiffs seek is truly unprecedented, fundamentally undemocratic, and should be soundly rejected by the Court.

A. Plaintiffs Carry a Heavy Burden in Asking This Court to Strike Down Hundreds of Perfectly Lawful Provisions

It is well-established that when "review[ing] the constitutionality of a legislative act, a federal court should act cautiously" because a "ruling of unconstitutionality frustrates the intent of the elected representatives of the people." *Regan v. Time*, 468 U.S. 641, 652 (1984); *see also Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 329 (2006). It is a "settled premise that severability is fundamentally rooted in a respect for separation of powers and notions of judicial restraint." *Florida ex rel. Atty. Gen.*, 648 F.3d at 1320-21. A court "must refrain from invalidating more of the statute than is necessary." *Booker v. U.S.*, 543 U.S. 220, 258. "Whenever an act of Congress contains unobjectionable provisions separable from those found to be unconstitutional, it is the duty of this court to so declare, and to maintain the act in so far as it is valid." *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987).

Accordingly, "when confronting a constitutional flaw in a statute," courts "sever its problematic portions while leaving the remainder intact." *Ayotte*, 546 U.S. at 328-29. Simply put, "[t]he presumption is in favor of severability." *Regan*, 468 U.S. at 653; *see also Florida ex rel. Atty. Gen.*, 648 F.3d at 1241 (concluding that the minimum coverage

requirement is severable from the rest of the ACA "because of the Supreme Court's strong presumption of severability and as a matter of judicial restraint").[22]

Determining "[w]hether an unconstitutional provision is severable from the remainder of the statute . . . is largely a question of legislative intent . . ." *Regan*, 468 U.S. at 653. But those seeking to overcome the presumption of severability face a heavy burden, one Plaintiffs cannot carry. "Unless it is *evident* that the Legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law." *Alaska Airlines*, 480 U.S. at 684 (emphasis added); *see also NFIB*, 567 U.S. at 587 ("Unless it is 'evident' that the answer is no, we must leave the rest of the Act intact."). It is axiomatic that the "touchstone for any decision about remedy is legislative intent, for a court cannot use its remedial powers to circumvent the intent of the legislature." *Ayotte*, 546 U.S. at 330; *see also NFIB*, 567 U.S. at 586 (same). As long as the rest of the statute is: (1) constitutionally valid; (2) capable of "functioning independently"; and (3) consistent with Congress's basic objectives in enacting the statute, the Court severs the unconstitutional provision and leaves the rest intact. *Booker*, 543 U.S. at 258-59.

Under these well-settled precedents, if a court finds a statutory provision unconstitutional, the court asks a simple question, "[w]ould the legislature have preferred what is left of its statute to no statute at all?" *Ayotte*, 546 U.S. at 330; *see also Leavitt v. Jane L.*, 518 U.S. 137, 143 (1996) ("The relevant question, in other words, is not whether the legislature would prefer (A+B) to B, because by reason of the invalidation of A that

[22] Plaintiffs flip the presumption of severability on its head, asserting that "the severability inquiry proceeds in two steps, both of which must be satisfied for a provision to be severable." ECF No. 40 at 27. But no case says that. Plaintiffs cite *Alaska Airlines*, but that decision confirms that a court *must sever* the unconstitutional provision from the rest of the statute "[u]nless it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not" so long as "what is left is fully operative as a law." *Alaska Airlines*, 480 U.S. at 684. Like every other Supreme Court case, *Alaska Airlines* affirms the strong presumption in favor of severability.

choice is no longer available. The relevant question is whether the legislature would prefer not to have B if it could not have A as well."). As shown below, there can be little doubt that the Congress that passed the ACA *and* the Congress that zeroed out the shared responsibility payment would have wanted the remainder of the ACA to stand. Plaintiffs have not come close to meeting their burden of proving that it is "evident" that Congress would have wanted Medicaid expansion, tax credits, consumer protections for 133 million Americans with preexisting conditions, and hundreds of other provisions to disappear along with the minimum coverage requirement.

B. Severability Clauses Are Unnecessary and There is No Presumption Against Severability From Failing to Include Them

As a preliminary matter, Plaintiffs' emphasis on the lack of a severability clause in the ACA is misplaced. *See* ECF No. 40 at 28-29. Plaintiffs claim that "a textual instruction in the statute as to severability carries presumptive, or even dispositive, sway without need to resort to the full-blown, two-part inquiry." *Id*. at 28. The Supreme Court has said precisely the opposite. In *Alaska Airlines*, it explained that "[i]n the absence of a severability clause, however, Congress' silence is just that—silence—and *does not raise a presumption against severability*." *Alaska Airlines*, 480 U.S. at 686 (emphasis added); *see also New York*, 505 U.S. at 186 (same).

Both the House and Senate drafting manuals, moreover, expressly provide that severability clauses are "unnecessary" and need not be included in legislation. *See* Office of the Legis. Counsel, U.S. Senate, *Legislative Drafting Manual* § 131, at 49 (1997); Office of the Legislative Counsel, U.S. H.R., *House Legislative Counsel's Manual on Drafting Style* § 328, at 33 (1995). The failure to include an "unnecessary" clause is immaterial, and the Supreme Court has said that "the ultimate determination of severability will rarely turn on the presence or absence of such a clause." *U.S. v. Jackson*, 390 U.S. 570, 585 n.27 (1968). Congress also placed the requirement to maintain minimum coverage or pay a shared responsibility payment in the Internal Revenue Code,

which *does* contain a severability provision. *See* I.R.C., § 5000A(a)-(b) (outlining the requirement to maintain minimum essential coverage or pay a penalty) and § 7852(a) (severability clause). For all of these reasons, the absence of a severability clause in the ACA does not rebut the long-established principle that "[t]he presumption is in favor of severability." *Regan*, 468 U.S. at 653. Plaintiffs' claims to the contrary are unfounded.

C. The ACA's Remaining Provisions Are Severable from the Minimum Coverage Provision

Plaintiffs assert that if the minimum coverage requirement is unconstitutional, every one of the ACA's hundreds of additional provisions must be invalidated because otherwise "the ACA's design of 'shared responsibility'" would be upset. ECF No. 40 at 35. In essence, Plaintiffs assert that invalidating the minimum coverage provision could create a chain reaction that might eventually cause some of the ACA's other provisions to operate differently than Congress intended, and thus the ACA must be struck down in its entirety. There is no merit to this argument.

1. The Congress that passed the TCJA deliberately left the rest of the ACA in place.

Striking down the entire ACA is improper because it would contravene congressional intent. *See NFIB*, 567 U.S. at 586 (the "touchstone for any decision about remedy is legislative intent, for a court cannot use its remedial powers to circumvent the intent of the legislature"). In seeking to enjoin the entire ACA based on the TCJA's recent amendment, Plaintiffs overlook the intent of the Congress that *passed* that amendment.[23] There can be no doubt that the current Congress—which zeroed out the shared responsibility payment—wanted the rest of the ACA to remain in place. That judgment represents the will of the people as expressed through their democratically

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[23] Plaintiffs focus exclusively on the intent of the Congress that passed the ACA. But that is the wrong focal point. None of Plaintiffs' cases involved a statutory provision amended by a *subsequent* Congress in a manner that purportedly makes the amended provision unconstitutional. Under these circumstances, the intent of the Congress that amended the provision should govern.

elected representatives, and courts may not impose a severability remedy that directly contradicts congressional intent. *Regan*, 468 U.S. at 653; *NFIB*, 567 U.S. at 586.

The legislative history of the TCJA conclusively demonstrates that Congress intended to preserve every aspect of the ACA other than eliminating the tax penalty for failing to comply with the minimum coverage requirement. For example, in the Senate Finance Committee hearing, Senator Toomey (R-PA) emphasized that:

> There are no cuts to Medicaid. There are no changes to the program. There are no reimbursement differences. There are no disqualifications for people to participate. None of that. We are simply saying if you cannot afford these ill designed plans, with respect to your family anyway, you are not going to have to pay this penalty.[24]

Senator Shelly Moore Capito (R-WV) remarked that: "No one is being forced off of Medicaid or a private health insurance plan by the elimination of the individual mandate. By eliminating the individual mandate, we are simply stopping penalizing and taxing people who either cannot afford or decide not to buy health insurance plans."[25]

Senator Orrin Hatch (R-UT) similarly asserted:

> Let us be clear, repealing the tax does not take anyone's health insurance away. No one would lose access to coverage or subsidies that help them pay for coverage unless they chose not to enroll in health coverage once the penalty for doing so is no longer in effect. No one would be kicked off of Medicare. No one would lose insurance they are currently getting from insurance carriers. Nothing—nothing—in the modified mark impacts Obamacare policies like coverage for preexisting conditions or restrictions against lifetime limits on coverage.[26]

He further emphasized that "[t]he bill does nothing to alter Title I of Obamacare, which includes all of the insurance mandates and requirements related to preexisting conditions and essential health benefits." *Id*. at 286.

Senator Tim Scott (R-SC) also declared from the Senate floor that "[a]nyone who doesn't understand and appreciate that the individual mandate and its effects in our bill take nothing at all away from anyone who needs a subsidy, anyone who wants to

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[24] *See Continuation of the Open Executive Session to Consider an Original Bill Entitled the Tax Cuts and Jobs Act Before the S. Comm. On Fin.*, Senate, 115th Congress, Nov. 15, 2017.

[25] 163 Cong. Rec. S7383 (daily ed. Nov. 29, 2017).

[26] *See supra* n.22 at 106.

continue their coverage—it does not have a single letter in there about preexisting conditions or any actual health feature."[27] There are many more examples in the record. Congress intentionally retained the community-rating and guaranteed-issue provisions that prevent discrimination on the basis of preexisting conditions, maintained federal subsidies for purchasing health insurance, and left Medicaid expansion untouched. That is the congressional intent that governs the outcome here. *See Ayotte*, 546 U.S. at 330 ("Would the legislature have preferred what is left of its statute to no statute at all?"). The answer is yes, because Congress made this unequivocally clear.

Congressional intent to keep the rest of the ACA intact is also demonstrated by the many times that Congress considered, but ultimately rejected, attempts to repeal this landmark legislation. Since its passage in 2010, some members of Congress have attempted to repeal the law an estimated 70 times, yet all such efforts have been rebuffed.[28] It would be difficult to imagine a more robust record of congressional intent to maintain the ACA as federal law. The Court should decline Plaintiffs' invitation to circumvent clear congressional intent in order to impose a result that Congress repeatedly declined to enact through the legislative process. *See NFIB*, 567 U.S. at 586.

2. The Congress that passed the ACA would have wanted the rest of the ACA to stand.

For the reasons outlined above, the Court's severability analysis should be governed by the 2017 Congress's stated intent to leave the rest of the ACA in place. But even if it were proper to consider the legislative intent of the 2010 Congress that passed the minimum coverage provision in its original (and fully constitutional) form—and to graft that intent onto a statutory amendment passed by a *different* Congress—that would still be of no assistance to Plaintiffs. For the many reasons outlined below, the Congress that

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[27] *See* 163 Cong. Rec. S7666 (daily ed. Dec. 1, 2017).

[28] *See* C. Stephen Redhead & Janet Kinzer, Cong. Research Serv., R43289, "4002112th, 113th, and 114th Congresses to Repeal, Defund, or Delay the Affordable Care Act" (2017), Appx. 192-219.

passed the ACA would not have wanted wholesale invalidation of this groundbreaking legislation just because a later Congress reduced the shared responsibility payment to $0.

a. The majority of the ACA's provisions went into effect years before the minimum coverage requirement.

For starters, there is no reason to believe that the Congress that adopted the ACA would have wished to invalidate the *majority* of the ACA's provisions which it effectuated years before the minimum coverage requirement took effect in 2014. For example, since January 1, 2010, the ACA has provided tax credits for small businesses to subsidize employee health coverage. *See* 26 U.S.C. § 45R. That same year, Congress prohibited insurers from imposing lifetime dollar limits on the value of coverage, from denying children coverage based on preexisting medical conditions, and from rescinding coverage except in the case of fraud. *See* 42 U.S.C. §§ 300gg-3, 300gg-11, 300gg-12. In 2011, numerous sections of the ACA implemented more efficient Medicare payment rates, which have been used to make millions of provider payments. *See, e.g.*, 42 U.S.C. § 1395w-4(e)(1)(H). Other major reforms effectuated in 2010-11 include: requiring individual and group health plans to cover preventive services without cost sharing; allowing children to stay on their parents' health insurance until age 26; and awarding funds to establish state-based Exchanges. 42 U.S.C. § 300gg-13 & 14; § 18031. By implementing most of the ACA years before the minimum coverage requirement, Congress made clear that it did not consider them dependent upon one another.

It is inconceivable that the Congress that passed the ACA would have wished to nullify tax credits for small businesses, eliminate important consumer protection reforms (including protections for children with preexisting conditions), and unwind millions of completed Medicare payments years later just because the minimum coverage provision was struck down. *See New York*, 505 U.S. at 186 ("the invalidation of one of the [statute's] incentives should not ordinarily cause Congress' overall intent to be frustrated.") Here, as the Eleventh Circuit found, excising the minimum coverage

provision "does not prevent the remaining provisions from being 'fully operative as a law.'" *Florida ex rel. Atty. Gen.*, 648 F.3d at 1322. All of the ACA's provisions, and especially those implemented years earlier, are severable from that requirement.

b. Most of the ACA has nothing to do with the individual insurance market.

The severability of the rest of the ACA is also shown by the fact that the "lion's share of the Act has nothing to do with private insurance, much less the mandate that individuals buy insurance." *Id.* at 1322. In light of the ACA's numerous stand-alone provisions addressing a vast array of diverse topics, it is not remotely "evident" that Congress would want the extraordinary disruption that would be caused by eliminating Medicaid expansion for millions of Americans, wiping out billions of dollars in premium tax credits that help low-income Americans purchase health insurance, reversing vital and long overdue changes to Medicare payment rates, eliminating tax credits for small businesses, and undoing numerous other wholly unrelated statutory provisions such as canceling reasonable break times for nursing mothers and restored funding for abstinence education. *See*, *e.g.*, 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); 26 U.S.C. § 36B; 42 U.S.C. § 1395w-44(p); 26 U.S.C. § 45R; 29 U.S.C. § 207(r); 42 U.S.C. § 710.

The extraordinarily varied array of issues addressed by the ACA distinguishes it from the Professional and Amateur Sports Protection Act (PASPA), which was invalidated in the Supreme Court's latest decision to address severability. *See Murphy v. Nat'l Collegiate Athletic Ass'n*, 138 S.Ct. 1461 (2018). The Court held that PASPA's provision prohibiting States from authorizing sports gambling was unconstitutional. *Id.* at 1478-81. It then went on to hold that the statute's remaining, closely related provisions—which prohibited: (1) state-run sports lotteries; (2) private sports gambling schemes operated pursuant to state authorization; and (3) the advertising of sports gambling—had to fall as well. *Id.* at 1482-84. This result flowed from PASPA's narrow, single-subject nature, and the Court's conclusions, grounded in an inquiry into legislative

intent, that: (1) legalizing sports gambling in private casinos while prohibiting state-run lotteries would get things "exactly backwards," *Id*. at 1483; (2) it would be a "weird result" for Congress to prohibit private arrangements that operated pursuant to now-lawful state authorization, i*d*. at 1484; and (3) it would be incongruous for federal law to prohibit the advertising of sports gambling once States were free to authorize that activity. *Id*. By contrast, a finding of total inseverability here would invalidate scores of provisions that have nothing to do with the minimum coverage requirement.

Such a result would be radically at odds with "the overwhelming majority of cases," in which "the Supreme Court has opted to sever the constitutionally defective provision from the remainder of the statute." *Florida ex rel. Atty. Gen.*, 648 F.3d at 1321 (citing historical examples). Wholesale invalidation of a statute is strongly disfavored and exceedingly rare. *See, e.g.*, *Ayotte*, 546 U.S. at 328-31. This case is no exception. If the Court concludes that the minimum coverage requirement is unconstitutional and declines to remedy that infirmity by striking down only the unconstitutional amendment itself (contrary to *Frost*), it should sever the minimum coverage provision from the rest of the ACA. *See Ayotte*, 546 U.S. at 328-29 ("when confronting a constitutional flaw in a statute," courts "sever its problematic portions while leaving the remainder intact.")

c. The ACA's community-rating and guaranteed-issue provisions are also severable from the mandate.

The result is no different when considering the ACA's "community-rating" and "guaranteed-issue" provisions, which are also severable from the minimum coverage requirement. The guaranteed-issue provision bars insurers from denying coverage to any individual because of the medical condition or medical history of that individual and/or his dependents. *See* 42 U.S.C. §§ 300gg-1, 300gg-3, 300gg-4. The community-rating requirement prohibits insurers from charging higher premiums because of their preexisting medical conditions. *Id*. at §§ 300gg(a), 300gg-4(b). These provisions ensure that 133 million Americans with preexisting conditions have access to affordable health

care. Aaron Dec. ¶¶ 13-16, Appx. 8-10. It is far from "evident" that the Congress that ushered in these important consumer protections would want them invalidated simply because a later Congress reduced the shared responsibility payment to $0.

To determine whether the Congress that passed the ACA would have wanted the community-rating and guaranteed-issue provisions to remain in place even without a minimum coverage requirement, it is essential to understand how the health insurance market operated at the time that the ACA passed. A decade ago, as a result of the medical underwriting practices of private insurers, between 9 and 12.6 million uninsured Americans "voluntarily sought health coverage in the individual market but were denied coverage, charged a higher premium, or offered only limited coverage that excludes a preexisting condition." *Florida ex rel. Atty. Gen.*, 648 F.3d at 1245; *see also NFIB*, 567 U.S. at 596-97 (Ginsburg, J. dissenting) (Before the ACA, "insurers routinely refused to insure" individuals with preexisting medical conditions "or offered them only limited coverage that did not include the preexisting illness").

Congress was concerned about these discriminatory industry practices, which prevented millions with preexisting conditions from obtaining affordable health insurance. Corlette Dec. ¶¶ 8-15, Appx. 087-090. A House Report discussing a 2009 health care bill that pre-dated final passage of the ACA stated that "health insurers—particularly in the individual market—have adopted discriminatory, but not illegal, practices to cherry-pick healthy people and to weed out those who are not as healthy." H.R. Rep. No. 111-299, Pt. 3, at 92 (2009).

(1) Congress independently sought to end discriminatory underwriting practices and to lower administrative costs.

One of Congress's main objectives in passing the ACA was to end these discriminatory insurance industry practices which denied affordable health insurance to millions of unhealthy individuals. *See* H.R. Rep. No. 111-443, Pt 2, at 975-76 (2010)

("To protect families struggling with health care costs and inadequate coverage, the bill ensures that insurance companies can no longer compete based on risk selection.") The legislative history of the ACA shows that this was a paramount concern of Congress, part and parcel of its ultimate goal of "increas[ing] the number and share of Americans who are insured." 42 U.S.C. § 18091(2)(C).

For example, Senator Dick Durbin (D-Illinois) stated during the Senate debate: "What we provide in this bill is protection against the ratings which discriminate against people because they are elderly or because they are women. We put limits to the rating differences that will be allowed in health insurance policies."[29] Senator Tim Johnson (D-South Dakota) explained that: "Under the Senate reform bill, all health insurers will be prohibited from using preexisting conditions to deny health care and it will be illegal for them to drop coverage when illness strikes."[30] Senator Russ Feingold (D-Wisconsin) averred that: "Because of this bill, lifetime and annual limits on coverage will be prohibited. Premiums cannot increase due to medical needs or illness. Insurers cannot charge women more than men for the same insurance policy. Restricting or denying coverage based on preexisting conditions is prohibited for all Americans, beginning with children effective 6 months after final passage of this bill."[31] This is just a small sample of the legislative history, which demonstrates that Congress passed the guaranteed-issue and community-rating provisions to ensure that everyone has access to affordable health insurance regardless of their health status.

In addition to protecting consumers with preexisting medical conditions, Congress also enacted the guaranteed-issue and community-rating provisions to reduce administrative costs and lower premiums. *Florida ex rel. Atty. Gen.*, 648 F.3d at 1323 (citing 42 U.S.C § 18091(a)(2)(J)). Congress found that insurers incurred $90 billion in

[29] 155 Cong. Rec. S13020 (daily ed. Dec. 11, 2009).
[30] 155 Cong. Rec. S13692 (daily ed. Dec. 21, 2009).
[31] 155 Cong. Rec. S13851 (daily ed. Dec. 23, 2009).

annual underwriting costs, representing 26%-30% of consumers' premium costs. *Id.* The community-rating and guaranteed-issue provisions were intended to "reduce the number of the uninsured and underwriting costs" to the benefit of consumers. *Id*; *see also* § 18091(2)(J) (the ACA's provisions, collectively, are intended to create "effective health insurance markets that do not require underwriting and eliminate its associated administrative costs."). These provisions will further these congressional purposes even in the absence of a shared responsibility payment. Congress would not wish to revert back to a situation where millions of Americans with preexisting conditions are denied access to affordable healthcare.

(2) It is not "evident" that Congress would want to discard these important consumer protections in the absence of the minimum coverage provision.

Plaintiffs assert that the Congress that enacted the ACA would not have wanted the community-rating and guaranteed-issue provisions to stand without a minimum coverage provision because: (1) the ACA states that all three provisions are "essential" to creating effective health insurance markets; and (2) adverse selection would cause premium rates would spike and a death spiral in the market may occur, which would be the opposite of Congress's goals in passing the ACA. ECF No. 40 at 30-35. But these arguments are overstated and ultimately insufficient to meet Plaintiffs' heavy burden of proving that it is "evident" that Congress would prefer that outcome. *NFIB*, 567 U.S. at 587.

Plaintiffs first assert that the community-rating and guaranteed-issue provisions are not severable "because of the specific findings that Congress inserted into the statutory text." ECF No. 40 at 30. Plaintiffs point to language stating that "[t]he requirement [to maintain minimum coverage] is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of preexisting conditions can be sold." *Id*. (citing 42 U.S.C. § 18091(2)(I)).

Based on this language, Plaintiffs claim that these provisions are "so interwoven" with the minimum coverage requirement that they must be invalidated too. *Id.*

There are a number of flaws with this argument. For starters, these congressional findings were designed to show that the requirement to maintain minimum essential coverage "is commercial and economic in nature, and substantially *affects interstate commerce* . . ." 42 U.S.C. § 18091(1) (emphasis added). In other words, these findings were drafted to demonstrate that Congress had constitutional authority under the Commerce Clause to require that most Americans purchase health insurance. *Id.* They do *not* reflect Congress's judgment as to whether the community-rating and guaranteed-issue provisions should cease to exist if the minimum coverage requirement were invalidated. And in light of *NFIB*—which held that Congress lacked authority under the Commerce Clause to require individuals to purchase insurance—these congressional findings are no longer relevant to the constitutional analysis for which they were crafted.

To be sure, Congress intended that the requirement to purchase health insurance, along with the community-rating and guaranteed-issue provisions, would work together harmoniously to increase the number of insured Americans and lower premiums. And it is true that without the minimum coverage provision, the community-rating and guaranteed-issue provisions will be less effective in achieving those goals. But contrary to Plaintiffs' assertions, severability does not turn on whether these remaining provisions will "function" in precisely the same "manner" that Congress intended.[32] ECF No. 40 at

[32] Plaintiffs repeatedly pluck the word "manner" from the *Alaska Airlines* decision and suggest that any time remaining statutory provisions do not function in the "manner" that Congress originally intended, they are not severable. *See* ECF No. 40 at 27. That is incorrect for two reasons. First, no subsequent Supreme Court decision has used the word "manner" when discussing severability principles, and it is doubtful that this one-time usage was intended to change the well-established legal standard. Second, at the end of the paragraph in *Alaska Airlines* which uses the word "manner," the Court affirmed that "the unconstitutional provision *must be severed* unless the statute created in its absence is legislation that Congress would not have enacted." *Alaska Airlines*, 480 U.S. at 685 (emphasis added). That is the traditional test that the Supreme Court has consistently followed, and which this Court should also follow.

35. That cannot be the correct legal standard; after all, presumably Congress never adopts any provision unless it believes it will help achieve its legislative objectives in a more efficient or effective manner. Framed properly, the question before the Court is whether Congress would "have preferred what is left of its statute to no statute at all[.]" *Ayotte*, 546 U.S. at 330. And as long as the community-rating and guaranteed-issue provisions are: (1) constitutionally valid; (2) capable of "functioning independently"; and (3) consistent with Congress's basic objectives in enacting the statute, the Court severs the unconstitutional provision and leaves the rest intact. *Booker*, 543 U.S. at 258-59.

The *Booker* factors are readily met. First, Plaintiffs do not assert that the community-rating and guaranteed-issue provisions are unconstitutional. Second, they "function independently" of the minimum coverage requirement because there is no functional dependency—or even any textual cross-reference—between these provisions. When considering this issue, the Eleventh Circuit explained:

> It is also telling that none of the insurance reforms, including even the guaranteed issue and coverage of preexisting conditions, contain any cross-reference to the individual mandate or make their implementation dependent on the mandate's continued existence.

Florida ex rel. Atty. Gen., 648 F.3d at 1324 (citing *Booker*, 543 U.S. at 260.)[33]

Booker describes the necessary functional and textual intertwining of statutory provisions that must be present in order to strike down more than just the unconstitutional provision. In that case, the Court held that 18 U.S.C. § 3553(b)(1), which made the Federal Sentencing Guidelines mandatory, violated the Sixth Amendment and therefore had to be excised from the Sentencing Reform Act of 1984. *Booker*, 543 U.S. at 245, 259. The Court left the remainder of the law intact, with one exception. *Id.* at 259. That exception was a statutory provision that "depends upon the Guidelines' mandatory nature"

[33] The Eleventh Circuit also noted that the prohibition on preexisting condition exclusions with respect to enrollees under 19 was implemented in 2010, four years *before* the minimum coverage requirement took effect in 2014. *Id.* at 1324. That is yet another reason why these provisions are not inherently dependent on one another.

and "contains critical cross-references to the (now-excised) § 3553(b)(1) and consequently must be severed and excised for similar reasons." *Id.* at 260; *see also Murphy*, 138 S. Ct. at 1482-84 (explaining the functional interdependence of PASPA's provisions concerning sports gambling). Aside from striking that single additional provision that was functionally and textually dependent on the unconstitutional provision that made the guidelines mandatory, the Court upheld the remainder of the statute. *Id.*

Unlike the single additional provision invalidated in *Booker*, nothing in the text of the ACA makes the community-rating and guaranteed-issue provisions functionally dependent on the existence of the minimum coverage provision. Nor do these provisions contain any "critical [textual] cross-references" to the minimum coverage provision. *Florida ex rel. Atty. Gen.*, 648 F.3d at 1324. The community-rating and guaranteed-issue provisions "can fully operate as a law" even without the minimum coverage requirement. *Id.*; *see also Booker*, 543 U.S. at 259 ("The remainder of the Act functions independently.") The second *Booker* factor is also met here.

Under the final *Booker* factor, the community-rating and guaranteed-issue provisions must stand if they are "consistent with Congress's basic objectives in enacting the statute." *Booker*, 543 U.S. at 259. As discussed previously, these requirements are fully consistent with Congress's desire to ensure that consumers with preexisting medical conditions have access to affordable health insurance. *See, e.g.,* H.R. Rep. No. 443, 111th Cong. 2d Sess. Pt 2, at 975-76 (2010) ("to protect families struggling with health care costs and inadequate coverage, the bill ensures that insurance companies can no longer compete based on risk selection.") All of the *Booker* factors are readily met.

(3) The adverse selection concern from 2010 is no longer a concern today.

Despite the overwhelming evidence demonstrating that severing the unconstitutional provision would be "consistent with Congress's basic objectives," Plaintiffs raise the "adverse selection problem." ECF No. 40 at 31. It is true that

Congress expressed concern that without the minimum coverage requirement, "many individuals would wait to purchase health insurance until they needed care and thus Congress wished to "minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums." 42 U.S.C. § 18091(2)(I). Because of this, in *NFIB* the federal government conceded that the community-rating and guaranteed-issue provisions are not severable from the minimum coverage requirement.

Any concern about adverse selection is not well founded in 2018. First, as Congress stated at the time, the three-prong approach that it adopted was intended to assist in "*creating* effective health insurance markets. . ." 42 U.S.C. § 18091(2)(I) (emphasis added). Congress was attempting to create brand new insurance markets from scratch, a major undertaking that involved tremendous uncertainty. But those markets were successfully created years ago, and even Plaintiffs do not assert that the minimum coverage provision is essential to *maintaining* those already-created health insurance markets. In fact, Plaintiffs themselves acknowledge that the "death spiral" scenario is far-fetched when they cite a 2017 CBO report about the effect of eliminating the shared responsibility payment. ECF No. 40 at 35.[34] CBO found that repealing the minimum coverage requirement would cause average premiums in the nongroup market to rise by about 10%, but that "nongroup insurance markets would continue to be stable in almost all areas of the country throughout the coming decade."[35] CBO 2017 Report at 1.

CBO recently released a new report confirming that even with the elimination of the tax penalty for the individual mandate: (1) the individual market will remain stable in most of the country over the next decade (though that stability may be fragile in some

[34] *See* Cong. Budget Off., Repealing the Individual Health Insurance Mandate: An Updated Estimate 2, Appx. 233.

[35] Although the CBO was assessing repeal of the individual mandate, it confirmed that "the results would be very similar" if the tax penalty was simply eliminated, but not repealed. *Id.*

places); (2) after the first year, premium increases will average only about 7% between 2019 and 2028; and (3) between 12 and 13 million Americans will continue to enroll in the individual insurance market.[36] Whatever the theoretical concern in 2010, Plaintiffs have offered no evidence suggesting that zeroing out the shared responsibility payment in 2019 will cause the individual insurance market to completely collapse because of adverse selection.

Second, the ACA itself contains many provisions that mitigate the risk of adverse selection. For example, the ACA permits insurance companies to "restrict enrollment in coverage . . . to open or special enrollment periods." 42 U.S.C. § 300gg-1(b)(1). Uninsured individuals, therefore, "cannot literally purchase insurance on the way to the hospital." *Florida ex rel. Atty. Gen.*, 648 F.3d at 1324 n.139. The ACA allows up to a 90-day waiting period for group coverage eligibility, and imposes no limit on the waiting period that insurers can impose in the individual market. *Id.* Uninsured individuals who forgo health insurance because they are currently healthy run a serious risk of becoming ill and requiring medical treatment prior to the next enrollment period.

Third, millions of healthy individuals will continue to purchase insurance because the ACA provides *billions* of dollars in premium tax credits to subsidize those purchases. *See* 26 U.S.C. § 36B; CBO August 2017 report at 13 (estimating that the federal government would spend $247 billion on the ACA's subsidies between 2017-2026).[37] In fact, nearly 12 million Americans purchased health insurance through the ACA's exchanges for 2018, and the vast majority of them (83%) did so with the help of premium tax credits.[38] And the CBO expects that number to *increase* over the coming decade even

[36] *See* Cong. Budget Off., Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028, 2-3, 5 (2018). Appx. 275-276, 278.

[37] Cong. Budget Off., The Effects of Terminating Payments for Cost-Sharing Reductions 13 (2017). Appx. 316.

[38] *See* Ctrs. for Medicare & Medicaid Servs., Health Insurance Exchanges 2018 Open Enrollment Period Final Report (2018). Appx. 319-322.

without a shared responsibility payment.[39] Millions of healthy Americans will continue to purchase subsidized health insurance, which undercuts the concern that only the sick will buy insurance without a tax penalty for not doing so. It is also worth noting that the shared responsibility payment by itself was a weak incentive to purchase health insurance, even before the penalty was reduced to zero.[40] As the Eleventh Circuit explained, the scope and effect of the shared responsibility payment was seriously constrained by "its three exemptions, its five exceptions to the penalty, and its stripping the IRS of tax liens, interests, or penalties and leaving virtually no enforcement mechanism." *Florida ex rel. Atty. Gen.*, 648 F.3d at 1326.

For all of these reasons, the decade-old and entirely theoretical risk of excessive adverse selection causing the individual market to collapse cannot rebut the strong presumption of severability today. As the Eleventh Circuit correctly concluded, eliminating the minimum coverage provision may make the community-rating and guaranteed-issue provisions "*less desirable*," but "it does not ineluctably follow that Congress would find the two reforms *so* undesirable without the mandate as to prefer not enacting them at all." *Florida ex rel. Atty. Gen.*, 648 F.3d at 1327. In light of the "heavy burden needed to rebut the presumption of severability" and the "duty to refrain from invalidating more of a statute than is necessary," that Court "sever[ed] the individual mandate from the remaining sections of the Act." *Id*. at 1323, 1327-28. If this Court reaches the severability question, it should do the same.

For all of these reasons, even if the minimum coverage requirement were found to be unconstitutional, and even if the Court declined to follow *Frost* and enjoin only the

[39] *See* Cong. Budget Off., Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028 5 (2018). Appx. 278.

[40] *See, e.g.*, *Examining the Effectiveness of the Individual Mandate under the Affordable Care Act: Hearing before the H. Comm. on Ways and Means Subcommittee on Oversight*, 115th Cong. (2017) (Statement of Thomas Miller, Resident Fellow, American Enterprise Institute). Appx. 324-335.

recent amendment, the rest of the ACA is fully severable and should be left in place.

IV. PLAINTIFFS HAVE NOT MET THEIR BURDEN OF DEMONSTRATING IRREPARABLE INJURY

For the reasons outlined above, Plaintiffs are unlikely to prevail on the merits of their legal claims. That is reason enough to deny the preliminary injunction. *See Nichols*, 532 F.3d at 372. But Plaintiffs also cannot demonstrate that they will suffer irreparable injury in the absence of injunctive relief. The individual Plaintiffs will suffer no harm because it is perfectly lawful for them to pay a tax of $0 instead of obtaining ACA-compliant insurance. And the shared responsibility payment that Congress zeroed out applies to *individuals*, not to States. Plaintiff States, therefore, cannot possibly be harmed by the reduction of a tax that never applied to them in the first place. The harms they complain of flow from other ACA provisions whose constitutionality is not being challenged here. Plaintiff States also mischaracterize the nature and extent of their costs, benefits, and obligations under the ACA. None of the Plaintiffs have come close to demonstrating the type of irreparable injury that would support a preliminary injunction.

A. The Individual Plaintiffs Will Not Suffer Any Injury From a $0 Tax

The individual Plaintiffs assert that they will suffer harm because they "value compliance with [their] legal obligations" and will "continue to maintain minimum essential health insurance coverage because [they] are obligated to comply with the Affordable Care Act's individual mandate." ECF No. 41 at 4, 8. But the notion that it is unlawful to pay a tax instead of obtaining ACA-compliant health insurance is incorrect as a matter of law. As Chief Justice Roberts explained in *NFIB*, "imposition of a tax nonetheless leaves an individual with a *lawful choice* to do or not do a certain act, so long as he is willing to pay a tax levied on that choice." *NFIB*, 567 U.S. at 574 (emphasis added); *see also id*. at n.11 ("Those subject to the individual mandate may lawfully forgo health insurance and pay higher taxes, or buy health insurance and pay lower taxes.").

Beginning next year, the individual Plaintiffs can fully comply with their legal obligations by declining to purchase health insurance and paying a tax penalty of $0. *NFIB*, 567 U.S. at 574. They will suffer no harm from that lawful choice, and therefore they will not suffer any injury—and will actually benefit—from the zeroing out of shared responsibility payment.[41] Where a party seeks to enjoin government action pursuant to a regulatory scheme, courts should not intervene unless the need for equitable relief is real and immediate. *Machete Productions, L.L.C. v. Page*, 809 F.3d 281, 288 (5th Cir. 2015). The individual Plaintiffs have thus failed to produce clear and convincing evidence that they will suffer irreparable harm if the requested injunction is denied.

B. None of the Harms Identified by the Plaintiff States Flow from Zeroing Out the Shared Responsibility Payment

The Plaintiff States contend that they are harmed because they are required to spend state funds to comply with the ACA's employer mandate, to implement parts of the Medicaid expansion, and because the ACA prevents them from enforcing their own laws and policies, among other alleged harms.[42] *See* ECF No. 40 at 43-50. But the States' claim of irreparable injury fails at the outset because none of their purported injuries are caused by the requirement that most *individuals* maintain insurance coverage. The shared responsibility payment applies to individuals, not to States. Plaintiff States, therefore, are not harmed by the reduction of a tax that never applied to them in the first place. And harm allegedly caused by other, non-challenged provisions has no legal

[41] To the extent that Plaintiffs contend that the ACA caused rising health premiums, they lack standing to assert such generalized grievances. *See Hotze v. Burwell*, 784 F.3d 984, 995 (5th Cir. 2015) (holding that a generic claim concerning health insurance premiums purportedly resulting from the ACA's minimum coverage requirement is insufficient to constitute cognizable injury for standing purposes, nor is it "fairly traceable" to that provision.)

[42] Plaintiffs also claim that the ACA harms the States as sovereigns because it "prevents them from applying their own laws and policies governing their own healthcare markets." ECF No. 40 at 44. But as long as Congress acts within its constitutional authority, it may preempt state law. "It is axiomatic that, under the Supremacy Clause, state laws that interfere with, or are contrary to the laws of [C]ongress, made in pursuance of the [C]onstitution are invalid." *Franks Inv. Co. v. Union Pac. R.R. Co.,* 534 F.3d 443, 445 (5th Cir. 2008).

relevance. Plaintiffs may not bootstrap alleged harm into the preliminary injunction analysis that is unrelated to the actual legal claims before the Court.

Recognizing this major flaw in their argument, Plaintiffs insert a footnote claiming that "[h]arms caused by provisions inseverable from an unconstitutional provision are both directly relevant to the proper scope of the injunction under traditional equitable principles, and support a party's standing to bring the lawsuit." ECF No. 40 at 43 (citing *Alaska Airlines*, 480 U.S. at 683). But *Alaska Airlines* says nothing of the sort. Indeed, the words "harm," "standing," and "injunction" do not appear *anywhere* in the decision, let alone any actual discussion about harms caused by provisions that are purportedly not severable. *Alaska Airlines*, 480 U.S. at 678-697. And in *Alaska Airlines*, the Supreme Court unanimously held that a legislative veto provision *was* severable from the rest of the federal statute. *Id*. at 697. The outcome in that case is precisely the same outcome that should occur here if the Court reaches the severability question.

Moreover, Plaintiffs must demonstrate by specific facts that there is a credible threat of immediate harm. Fed. R. Civ. P. 65(b). Here, even if Plaintiff States' alleged harm flowed from a $0 shared responsibility payment (which even they do not claim), the tax is not zeroed out until 2019, and will not cease generating revenue until 2020 or later. As such, the imminent harm needed to justify the requested relief is lacking. Plaintiff States have not shown that they will suffer any injury—let alone irreparable and imminent injury—from the reduction of a tax that never applied to them in the first place.

C. Plaintiffs Mischaracterize Their Costs and Obligations Under the ACA to Exaggerate Their Alleged Harm

Even if the Court's authority to issue a preliminary injunction turned on the broad policy debate over whether the ACA has been good or bad for the States (and it does not), Plaintiffs mischaracterize the nature and extent of their costs, benefits, and obligations under the ACA to exaggerate their purported harm. While repeatedly claiming that they are harmed because the ACA "forces" them to spend money, Plaintiffs fail to disclose the

many voluntary steps that they have taken to expand access to coverage for their residents by taking advantage of the federal dollars available under the ACA. For example, seven Plaintiff States elected to expand access to Medicaid pursuant to the ACA;[43] ten chose to expand access to CHIP for children of state employees pursuant to Section 10203(b)(2)(D) of the ACA and Dear State Health Official Letter No. 11-002 (Apr. 4, 2011);[44] four chose, pursuant to 42 C.F.R. § 435.150(c), to extend the new ACA eligibility group of former foster youth to cover youth from other states;[45] and three decided to take advantage of ACA Section 2202 to further extend presumptive eligibility for Medicaid and CHIP, among other examples.[46]

In addition, Texas decided to use Community First Choice (CFC), a new Medicaid option made possible by Section 2401 of the ACA, to expand access to home and community-based care.[47] As the Texas Human Services Commission explained to the state legislature in a report evaluating the CFC program, "[c]alculating the actual cost effectiveness […] requires not only information about costs, but also information about outcomes." It went on to explain that the program was a cost-effective choice because it allows Texas to draw down additional federal dollars, and because the up-front payments may obviate the need for the state to spend money on more expensive home and community-based Medicaid waiver or institutional care.[48] Plaintiff States' investments in healthcare on behalf of their residents belie their current litigation position that the

[43] Eyles Dec. ¶ 6, ECF No. 15-1 at 95.

[44] Kaiser Family Found., Medicaid and CHIP Eligibility, March 2018 Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey 2-9 (2018). Appx. 338-345.

[45] *Id*. at 346.

[46] *Id*. at 347.

[47] *See* Tex. Health and Hum. Servs., Community First Choice. Appx. 349-355.

[48] Tex. Health and Hum. Serv.s Comm'n, Report on the Cost-Effectiveness of Community First Choice in Star+Plus 2 (2017). Appx. 360. The Texas Commission also noted that some of the CFC outcomes were not as easily captured on a balance sheet, "such as increased independence, integration into the greater community, employment, and improved health and wellness." *Id.* at 364.

ACA's supposedly non-severable positions "will only add" to their alleged harm. ECF No. 40 at 43. Nor can any state resources devoted to implementing these *voluntary* choices be fairly characterized as "harm."[49]

Plaintiffs' complaints about the ACA's costs also fail to acknowledge the value of ACA covered services in preventing future medical costs, and improperly includes various sunk costs without any evidence that these costs would otherwise be redressed by an injunction. Plaintiffs claim that they have been harmed by ACA requirements to cover preventive health services, such as comprehensive tobacco cessation services for women. Muth Dec. ¶ 4, ECF No. 41 at 027-028. Yet the States never account for the long-term benefits of preventive health care, including improvements to children's learning, adults' productivity, seniors' quality of life, and overall improved financial, physical and mental wellbeing. Aaron Dec. ¶¶ 7, 9, Appx 004-006. And to the extent that the States complain about the expenditure of resources relating to initial ACA implementation,[50] there is no evidence that these costs are ongoing or will be redressed by a forward-looking injunction. Aaron Dec. ¶¶ 46-165, Appx. 025-060.[51]

In sum, Plaintiffs will not be injured in any way when the ACA's shared responsibility payment is reduced to $0 in 2019. No preliminary injunction should issue.

V. A PRELIMINARY INJUNCTION IS AGAINST THE PUBLIC INTEREST

As a final matter, the last two preliminary injunction factors—whether the threatened injury to Plaintiffs outweighs the threatened harm to Defendants from issuing the injunction and whether granting the injunction is against the public interest—strongly

[49] Plaintiffs also state that they must offer their full-time employees and their dependents minimum essential coverage or a tax penalty. ECF No. 40 at 43. But they fail to explain that self-insured plans, such as Texas' Health Select, may exempt themselves from the ACA's minimum coverage requirement. 42 U.S.C. §300gg-21(a)(2); Duran Dec. ¶ 5, ECF No. 41, 012.

[50] *See, e.g.*, Muth Dec. ¶ 7, ECF No. 41 at 029.

[51] Plaintiffs improperly include other ACA-related expenses that sun-set and would not be affected by prospective relief. Duran Dec. ¶ 14 (PCOR fees which sunset in FY2019), and ¶ 15 (Transitional Reinsurance Program which ended in FY 2017). ECF No. 41 at 015.

tip the scales against issuing any injunction. *See Canal Auth. of State of Fla.*, 489 F.2d at 572. The alleged injuries to Plaintiffs are far outweighed by the devastating harm to the Defendant States and their citizens that enjoining the ACA would cause. Damaging this country's healthcare system, completely upending a sector that constitutes almost 1/5 of the national economy, and depriving tens of millions of Americans of health insurance is not in the public interest.

A. The Alleged Harm to Plaintiffs is Far Outweighed by the Devastating Harm to Defendant States and Their Citizens

There can be little doubt that that the alleged harm to Plaintiffs is far outweighed by the devastating harm to Defendants. Reducing the shared responsibility payment to $0 actually benefits the individual Plaintiffs, and does not affect the Plaintiff States. In contrast, Intervenor-Defendants stand to lose over half a *trillion* dollars in federal funds to provide healthcare for their citizens; approximately six million newly enrolled beneficiaries residing in their States would be kicked off of Medicaid; their state-run exchanges would be wiped out; and millions of the Defendants' residents would lose access to billions of dollars in tax credits for purchasing health insurance and protections from being discriminated against on the basis of preexisting health conditions. *See supra* at 3-12. By any objective measure—and even accepting Plaintiffs' alleged injuries at face value—the harm that would occur from enjoining the ACA far outstrips the purported injury to Plaintiffs.

The Supreme Court recently reiterated that the purpose of interim injunctive relief is "not to conclusively determine the rights of the parties," but instead to "balance the equities as litigation moves forward." *Trump v. Int'l Refugee Assistance Project*, 137 S. Ct. 2080, 2087 (2017). Here, the equities weigh heavily in favor of Defendants and counsel against wholesale invalidation of the ACA—especially on a preliminary basis. Plaintiffs have not shown—and cannot show—that their alleged injury *outweighs* the devastating harm that an injunction would cause. *Karaha Bodes Co.*, 335 F.3d at 363.

B. Issuing a Preliminary Injunction is Also Against the Public Interest Because It Would Upend the Status Quo

Even setting aside the fact that the equities tip strongly against issuing an injunction, entering such interim relief is also against the public interest because it would upend the status quo. The underlying purpose of a preliminary injunction "is merely to preserve the status quo until the merits of a case can be adjudicated." *Morgan v. Fletcher*, 518 F.2d 236, 239 (5th Cir. 1975). Here, Plaintiffs are not seeking to preserve the status quo; they are seeking to completely disrupt it without any analysis or even discussion as to the immediate, nationwide consequences. Plaintiffs have not come close to showing that this case is one of the "*rare instances* [where] the issuance of a mandatory preliminary injunction [is] proper." *Tate*, 634 F.2d at 870 (emphasis added).

The relief that Plaintiffs seek would unravel nearly a decade of building healthcare systems around the ACA's landmark reforms that strengthened consumer protections, made insurance markets more accessible and affordable to millions of Americans, expanded and improved Medicaid, modified and improved Medicare payments and benefits, and enhanced prevention and public health programs, among the many other ACA reforms from which all States have benefitted. The reliance interests that have formed over the past eight years that the ACA has been in existence are enormous. Corlette Dec. ¶¶ 52-60, Appx. 100-104; Eyles Dec. ¶¶ 4-12, ECF No. 15-1 at 94-99. Defendant States would experience serious harm and increased costs from the dismantling of their state administrative structures, created to work in conjunction with the ACA. Zucker Dec. ¶ 1, Appx. 395-397; Wilson Dec. ¶ 3, Appx. 392-394; Johnson Dec. ¶¶ 4, 8, Appx. 115-116; Lee Dec. ¶ 2, Appx. 130; Kent ¶ 2, Appx. 119; Kofman ¶ 1, Appx. 122-123; DeBenedetti Dec. ¶ 4, Appx. 106-107; Allen Dec. ¶¶ 2-9, Appx. 410-415; Bohn ¶¶ 4-5, 7-8, 10, Appx. 427-429. New York, for example, would need to rebuild its electronic eligibility systems based on new criteria, impacting millions of its residents who would need to be provided notice and given due process through an appeal; at an

estimated cost of nearly $900 million. Zucker Dec. ¶ 1, Appx. 395-397; *see also* Sherman Dec. ¶ 3; Appx. 417-418. It is against the public interest to provide relief that is typically intended to *freeze* the status quo in order to impose chaos and havoc on the *actual* status quo. The Court should not impose the "extraordinary and drastic remedy" of a preliminary injunction under these circumstances. *White*, 862 F.2d at 1211.

C. Any Injunction Issued by the Court Should Only Apply to the Individual Plaintiffs

If the Court is inclined to issue a preliminary injunction, it should limit that injunction to any unconstitutional application of the ACA to the individual Plaintiffs themselves. "A district court abuses its discretion if it issues an injunction that 'is not *narrowly tailored* to remedy the specific action which gives rise to the order as determined by the substantive law at issue.'" *ODonnell v. Harris Cty., Texas*, 882 F.3d 528, 537 (5th Cir. 2018) (emphasis added). If a $0 tax penalty makes the minimum coverage requirement unconstitutional, the Court should enjoin that requirement as it applies to the individual Plaintiffs but go no further. A sweeping, nationwide injunction is not warranted when precisely two individuals subjected to that provision have sued.

Finally, if the Court wishes to issue a nationwide injunction that would enjoin the entire ACA, it should require Plaintiffs to provide a security that is sufficient to "pay the costs and damages sustained by any part found to have been wrongfully enjoined or restrained." Fed. R. Civ. P. 65(c). As discussed previously, the Defendant States would collectively lose $608.5 billion dollars in ACA funds to provide healthcare to their residents. *See* Aaron Dec. ¶¶ 53, 60, 67, 74, 81, 88, 95, 102, 109, 116, 123, 130, 137, 144, 151, 158, 165, Appx. 028-060. The Court should require Plaintiffs to post a bond in that amount so that Defendants can be made whole should the injunction be reversed.

CONCLUSION

Plaintiffs' application for a preliminary injunction should be denied.

Dated: June 7, 2018

Respectfully submitted,

Xavier Becerra
Attorney General of California
Julie Weng-Gutierrez
Senior Assistant Attorney General
Kathleen Boergers
Supervising Deputy Attorney General

/s/ Neli N. Palma

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Certificate of Service

On June 7, 2018 I electronically submitted the foregoing document with the clerk of court for the U.S. District Court, Northern District of Texas, using the electronic case filing system of the court. I hereby certify that I have served all counsel and/or *pro se* parties of record electronically or by another manner authorized by Federal Rule of Civil Procedure 5 (b)(2).

s/ M. Schoenhardt

From:	Diamond, Joshua
To:	Clark, Charity
Subject:	FW: Title X website options
Date:	Monday, July 2, 2018 12:54:00 PM

Please see below. Josh

Joshua R. Diamond, Deputy Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, Vermont 05609
802-828-3175
joshua.diamond@vermont.gov

PRIVILEGED & CONFIDENTIAL COMMUNICATION: This communication may contain information that is privileged, confidential, and exempt from disclosure under applicable law. DO NOT read, copy or disseminate this communication unless you are the intended addressee. If you are not the intended recipient (or have received this E-mail in error) please notify the sender immediately and destroy this E-mail. Vermont's lobbyist registration and disclosure law applies to certain communications with and activities directed at the Attorney General. Prior to any interactions with the Office of the Vermont Attorney General, you are advised to review Title 2, sections 261-268 of the Vermont Statutes Annotated, as well as the Vermont Secretary of State's most recent compliance guide available at https://www.sec.state.vt.us/elections/lobbying.aspx.

From: Spottswood, Eleanor
Sent: Wednesday, June 13, 2018 2:22 PM
To: Diamond, Joshua <Joshua.Diamond@vermont.gov>
Subject: RE: Title X website options

Josh,

Here is some revised language, per our recent conversation.

- HHS is trying to defund low-income healthcare organizations such as Planned Parenthood
- It's writing new rules for distributing money from Title X, the only nationwide program for affordable birth control and reproductive health care
- Vermont has relied on Title X funding for the last 30 years to fund comprehensive reproductive healthcare, especially in low-income and rural areas
- Title X clinics never use Title X funding for any abortion services
- HHS's new rules:
    - Require doctors to provide incomplete and misleading information to pregnant patients
    - Promote abstinence over effective forms of birth control
    - Decrease doctor-patient confidentiality for teens and vulnerable adults

    - Impose dangerous barriers on the constitutional right to access abortion
    - Apply even to clinics that don't receive Title X money
    - Increase general costs of healthcare for patients and doctors
    - Disproportionately impact:
        - people living in rural areas
        - poor people
        - women
        - people of color
        - teens
        - victims of domestic and sexual violence
        - people without adequate health insurance
        - and other marginalized groups
- Tell the Trump administration:
    - You want the federal government to keep funding evidence-based healthcare
    - You want the same Title X rules that have worked well for Vermonters for the last 30 years
    - The new rules will hurt Vermonters' access to healthcare
- Or, if you have a different message for the Trump administration, you can say that, too

And, FYI: Here is Planned Parenthood's summary of Title X and the new reg. Here is their web portal with their semi-scripted public comment.

Here is the federal page for submitting comments on this rule, which is formally known as "Compliance with Statutory Program Integrity Requirements."

Let me know if I can provide anything else.

Ella

From: Spottswood, Eleanor
Sent: Wednesday, June 13, 2018 9:31 AM
To: Diamond, Joshua <Joshua.Diamond@vermont.gov>; Clark, Charity <Charity.Clark@vermont.gov>
Subject: Title X website options

Josh and Charity,

Per Josh's request, here are some draft options for language for the potential Title X comment website. I have tried to provide slightly more detail without mentioning abortion or reproductive health.

- This regulation restricts access to healthcare for poor people
- HHS is trying to restrict what doctors can tell their patients
    - Even for accurate, medically sound information, requested by the patient
- HHS is disrupting proven, evidence-based methods of delivering healthcare that have been

practiced for the last 30 years
- HHS is restricting the confidentiality that teens and vulnerable adults can expect in accessing healthcare
- This regulation will result in essential low-income clinics closing and/or restricting services
- This regulation imposes burdensome/unnecessary federal restrictions on how the state funds public health services

Let me know if I can provide anything else.

Ella

Eleanor L.P. Spottswood
Assistant Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, Vermont 05609
802-828-3178
eleanor.spottswood@vermont.gov

From:	Diamond, Joshua
To:	Clark, Charity
Subject:	Title X comments and potential press conference.
Date:	Wednesday, July 4, 2018 11:00:13 PM
Attachments:	Web Comments.docx

Charity,

Please see attached. The attached document reflects edits to a document created by Ella to provide a web page for folks to provide comments support of Title X.

I'd appreciate your thoughts and welcome any suggested edits. Maybe we could touch base with Jason tomorrow as well about hosting a web page at CAP that would facilitate the sending of comments similar to the FDA regulations impacting maple sugar. It is my understanding that Jason was responsible for the technical success in creating a portal for filing such comments.

Let's also touch base about a potential press event on this subject as well.

Thanks and look forward to talking tomorrow.

Best, Josh

Joshua R. Diamond, Deputy Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, Vermont 05609
802-828-3175
joshua.diamond@vermont.gov

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Please join the Vermont Attorney General's Office in providing comments opposing the United States Department of Health and Human Services' ("HHS") efforts to change Title X regulations that would adversely impact equal access to health care by women in Vermont and across America.

Title X has provided federal funding to insure equal access to health care for women since 1970. This includes access to affordable birth control and reproductive health care to people who cannot afford health care services on their own.

In Vermont this includes ____ women who have access to health care as a result of Title X funding. The basic primary and preventive health care services funded by Title X include: wellness exams, lifesaving cervical and breast cancer screenings, birth control, contraception education, and testing for sexually transmitted diseases and HIV testing. Providers of Title X health care include Planned Parenthood.

HHS is trying is trying to defund low-income healthcare organizations such as Planned Parenthood. It is writing new rules for distributing money from Title X, the only nationwide program for affordable birth control and reproductive health care. Title X clinics never use Title X funding for any abortion services

HHS's new rules condition funding by:

- Requiring doctors to provide incomplete and misleading information to pregnant patients
- Promote abstinence over effective forms of birth control
- Decrease doctor-patient confidentiality for teens and vulnerable adults
- Impose dangerous barriers on the constitutional right to access abortion
- Increase general costs of healthcare for patients and doctors
- Disproportionately impact:
  - people living in rural areas
  - poor people
  - women
  - people of color
  - teens
  - victims of domestic and sexual violence
  - people without adequate health insurance
  - and other marginalized groups

The Vermont Attorney General's Office encourages Vermonters to tell HHS:

- You want the federal government to keep funding evidence-based healthcare
- You want the same Title X rules that have worked well for Vermonters for the last 30 years
- The new rules will hurt Vermonters' access to healthcare
- Or, if you have a different message for HHS and the Trump administration, you can say that, too!

Comments can be filed by going to the following hyperlink:

###XXX####

Here is PP's web portal with their semi-scripted public comment.

Here is the federal page for submitting comments on this rule, which is formally known as "Compliance with Statutory Program Integrity Requirements."

Please join the Vermont Attorney General's Office in providing comments opposing the United States Department of Health and Human Services' ("HHS") efforts to change Title X regulations that would adversely impact equal access to health care by women in Vermont and across America.

Title X has provided federal funding to insure equal access to health care for women since 1970. This includes access to affordable birth control and reproductive health care to people who cannot afford health care services on their own.

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From:	Clark, Charity
To:	Spottswood, Eleanor
Cc:	Wemple, Doug
Subject:	Title X rules page press conference
Date:	Tuesday, July 10, 2018 2:19:00 PM
Attachments:	Template Press Release.docx

Hi, Ella,

I'm starting work preparing for a press conference to launch the Title X rules change feedback website we are designing. Will you be the one taking a first crack at a press release? I've attached a template for your use.

We are tentatively holding Wednesday, July 18th for a press conference. I will send you a calendar invite for the presser as well as the prep session, which I have slotted for Monday. Please let me know if you have a conflict. The date is so far tentative due to another couple of press conferences we are working on.

No later than Monday, I will need to send out a media advisory enticing the press to the press conference. The media advisory lists the when, where, what. I will get started on the advisory this week.

As to location, TJ, Josh, and I were thinking a women's health center would be good, and I proposed Maitri in South Burlington. I'm nervous about the limited parking there, so I would want to suss it out first. I thought I'd check with you first to see if you had other ideas.

Another question we should be working on is, who should the speakers be at this particular press conference? I think Planned Parenthood should be there. Anyone else?

Finally, are there any particular reporters who you think would be interested in this issue? After the media advisory goes out, Doug and I can reach out to any of these reporters directly to make sure they know of the press conference.

Thanks!
Charity

Charity R. Clark
Chief of Staff
Office of the Attorney General
109 State Street
Montpelier, Vermont 05609
802-828-3737

STATE OF VERMONT
OFFICE OF THE ATTORNEY GENERAL
109 STATE STREET
MONTPELIER, VT 05609-1001

FOR IMMEDIATE RELEASE: [DATE]

CONTACT: [NAME]
[TITLE]
[PHONE]

[HEADLINE, PREFERABLY DO NOT BEGIN 'ATTORNEY GENERAL DONOVAN…"]

[Sub-headline, if needed]

[LOCATION, USUALLY MONTPELIER] – This paragraph should summarize the entire release in just a few sentences. Just by reading this paragraph, a news reporter will know all that is important about this topic. It's a road map for the rest of the release

"Quote from T.J.," Attorney General Donovan said.

These next paragraphs dig deeper into the topic. You can add more quotes from T.J., or stakeholders, when appropriate. The key to a successful press release, other than a grabby headline, is short sentences. Channel your inner Hemingway and be pithy. Resist the instinct to use legal jargon.

The final paragraph is a good place to list all the states signing on to a multi-state. It's also a good place to provide contact information for the Consumer Assistance Program or other contact info for the public.

# # #

From: Spottswood, Eleanor
To: Clark, Charity
Cc: Wemple, Doug
Subject: RE: Title X rules page press conference
Date: Tuesday, July 10, 2018 2:45:37 PM

Hi Charity,

I am happy to try drafting a press release. I'll take a look at the template.

I don't have any initial thoughts about the location for the conference.

I also don't know much about which reporters might be interested, but I can try to ask around. Aki Soga at the Free Press was the one who talked to Josh and me about the Kennedy retirement's impact on abortion access, though that is a much sexier issue than regulatory notice and comment.

Josh and I had discussed maybe getting someone from legislative leadership to be present at the press conference—not sure if that was intended as a speaking role.

I'm pretty new to the area so I still don't know all of the players that I should.

Also—my intern, Hannah Clarisse, has helped me out with some research for this project, so I am going to invite her to attend the press conference as well.

Ella

From: Clark, Charity
Sent: Tuesday, July 10, 2018 2:19 PM
To: Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Cc: Wemple, Doug <Doug.Wemple@partner.vermont.gov>
Subject: Title X rules page press conference

Hi, Ella,

I'm starting work preparing for a press conference to launch the Title X rules change feedback website we are designing. Will you be the one taking a first crack at a press release? I've attached a template for your use.

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Another question we should be working on is, who should the speakers be at this particular press conference? I think Planned Parenthood should be there. Anyone else?

Finally, are there any particular reporters who you think would be interested in this issue? After the media advisory goes out, Doug and I can reach out to any of these reporters directly to make sure they know of the press conference.

Thanks!
Charity

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802-828-3737

From: Clark, Charity
To: Spottswood, Eleanor
Cc: Wemple, Doug
Subject: RE: Title X rules page press conference
Date: Tuesday, July 10, 2018 2:57:00 PM

Thanks, Ella! Definitely invite Hannah. I will let you know when we have a firm date, time, and location, but I am going to try hard to stick to 7/18 since there is a deadline for the comment period for these rules.

Charity

From: Spottswood, Eleanor
Sent: Tuesday, July 10, 2018 2:46 PM
To: Clark, Charity <Charity.Clark@vermont.gov>
Cc: Wemple, Doug <Doug.Wemple@partner.vermont.gov>
Subject: RE: Title X rules page press conference

Hi Charity,

I am happy to try drafting a press release. I'll take a look at the template.

I don't have any initial thoughts about the location for the conference.

I also don't know much about which reporters might be interested, but I can try to ask around. Aki Soga at the Free Press was the one who talked to Josh and me about the Kennedy retirement's impact on abortion access, though that is a much sexier issue than regulatory notice and comment.

Josh and I had discussed maybe getting someone from legislative leadership to be present at the press conference—not sure if that was intended as a speaking role.

I'm pretty new to the area so I still don't know all of the players that I should.

Also—my intern, Hannah Clarisse, has helped me out with some research for this project, so I am going to invite her to attend the press conference as well.

Ella

From: Clark, Charity
Sent: Tuesday, July 10, 2018 2:19 PM
To: Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Cc: Wemple, Doug <Doug.Wemple@partner.vermont.gov>
Subject: Title X rules page press conference

Hi, Ella,

I'm starting work preparing for a press conference to launch the Title X rules change feedback website we are designing. Will you be the one taking a first crack at a press release? I've attached a template for your use.

We are tentatively holding Wednesday, July 18th for a press conference. I will send you a calendar invite for the presser as well as the prep session, which I have slotted for Monday. Please let me know if you have a conflict. The date is so far tentative due to another couple of press conferences we are working on.

No later than Monday, I will need to send out a media advisory enticing the press to the press conference. The media advisory lists the when, where, what. I will get started on the advisory this week.

As to location, TJ, Josh, and I were thinking a women's health center would be good, and I proposed Maitri in South Burlington. I'm nervous about the limited parking there, so I would want to suss it out first. I thought I'd check with you first to see if you had other ideas.

Another question we should be working on is, who should the speakers be at this particular press conference? I think Planned Parenthood should be there. Anyone else?

Finally, are there any particular reporters who you think would be interested in this issue? After the media advisory goes out, Doug and I can reach out to any of these reporters directly to make sure they know of the press conference.

Thanks!
Charity

Charity R. Clark
Chief of Staff
Office of the Attorney General
109 State Street
Montpelier, Vermont 05609
802-828-3737

From:	Spottswood, Eleanor
To:	Duquette-Hoffman, Jason; Diamond, Joshua; Clark, Charity
Cc:	Bailey, Jay
Subject:	RE: Suggested edits to Title X rules page
Date:	Wednesday, July 11, 2018 5:54:51 PM
Attachments:	2018-07-11 Title X website edits ELPS.docx

Hi Jason,

I'm so sorry to bother you again. But, after talking it over with Charity and TJ today, we want to make the attached additional edits to the website (I copied and pasted the website text and then edited in track changes—let me know if anything is not clear). Mostly this is to make the language more inclusive and gender-neutral. Also a couple of typo corrections.

I'm guessing we will want this in the high impact/time limited section of the homepage, as the deadline for comments is July 31.

Thank you again for your work on this while you are out!

Ella

From: Duquette-Hoffman, Jason
Sent: Wednesday, July 11, 2018 11:59 AM
To: Diamond, Joshua <Joshua.Diamond@vermont.gov>; Clark, Charity <Charity.Clark@vermont.gov>
Cc: Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>; Bailey, Jay <Jay.Bailey@vermont.gov>
Subject: Re: Suggested edits to Title X rules page

Charity's and Ella's text and content changes have been made (the comma-deprived section was supposed to be bullets.... :-)), so it should be all set. I will be back in the office from bereavement leave on Tuesday, but if you want it live before then Jay can publish it.

You should think about whether you want a link to it from a slider photo on the homepage, or just linked from the press release news post. The slider at the top of the homepage is best used for high-priority/impact but time-limited content, or to highlight informational items with longer use times and impact than a news post. If you want to place it in the slider, there is a full-size version of the image in the post uploaded to the media files that Jay can use.

Best,

Jason

From: Diamond, Joshua
Sent: Tuesday, July 10, 2018 3:57:45 PM
To: Clark, Charity; Duquette-Hoffman, Jason

Cc: Spottswood, Eleanor
Subject: RE: Suggested edits to Title X rules page

Folks, the edits look good to me as well.

Ella, we welcome any final input on your end before the web page goes live.

Thanks. Josh

Joshua R. Diamond, Deputy Attorney General
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-----Original Message-----
From: Clark, Charity
Sent: Tuesday, July 10, 2018 1:57 PM
To: Duquette-Hoffman, Jason <jason.duquette-hoffman@vermont.gov>
Cc: Diamond, Joshua <Joshua.Diamond@vermont.gov>
Subject: Suggested edits to Title X rules page

First of all, beautiful photo of Carrie and Simone. I think that's perfect. My edits to page 1 are attached. My only edits to page 2 are to the final drop-down, which is missing a whole lotta commas.

Thanks for all your work on this, Jason. Please let me know if there's someone else who can make these edits in your absence. We have a tentative press conference date and launch for this website, next Wednesday 7/18.

Charity

Action Alert: Help us protect access to ~~women's~~ reproductive health care!

The United States Department of Health and Human Services~~'~~ is trying ~~is trying~~ to defund healthcare organizations, such as Planned Parenthood, that help people who have low incomes. It is writing new rules for distributing money from Title X, the only nationwide program for affordable birth control and reproductive health care.

You can help!

Join us in opposing the HHS efforts to change Title X regulations that would adversely impact equal access to reproductive health care ~~by women~~ in Vermont and across America. Comment now on their proposed new rules:

PROTECT ACCESS TO HEALTH CARE ~~FOR WOMEN~~. COMMENT NOW!

Tell HHS:

- You want the federal government to keep funding evidence-based healthcare
- You want the same Title X rules that have worked well for Vermonters for the last 30 years
- The new rules will hurt Vermonters' access to healthcare
- If you are comfortable, feel free to share your story about the impact that access to reproductive health care has had on your life

Or, if you have a different message for HHS and the Trump administration, you can say that, too!

Title X clinics never use Title X funding for any abortion services.

Find out more….

What is Title X and how does it provide access to ~~women's~~ reproductive health care services?

Title X has provided federal funding to ensure ~~equal~~ accessible, low-cost ~~to~~ reproductive health care ~~for women~~ since 1970. This includes ~~access to~~ affordable birth control and ~~reproductive~~ other preventive health care for~~to~~ people who cannot afford health care services on their own. ~~In Vermont this includes 7,796 women~~8,719 Vermont residents ~~who~~ currently have access to health care as a result of Title X funding. The basic primary and preventive health care services funded by Title X include:

- wellness exams;

- lifesaving cervical and breast cancer screenings;
- birth control, contraception education, and testing for sexually transmitted diseases and HIV ~~testing~~.

Providers of Title X health care include Planned Parenthood.

How would these new rules limit access to health care ~~for women~~?

HHS's new rules condition funding by:

- Requiring doctors to provide incomplete and misleading information to pregnant patients;
- Promoting 'natural family planning methods' over more effective forms of birth control;
- Decreasing doctor-patient confidentiality for teens and vulnerable adults;
- Imposing dangerous barriers on the constitutional right to access abortion;
- Increasing general costs of healthcare for patients and doctors.

Who would these new rules affect most?

The proposed new HHS rules would disproportionately impact:

- people living in rural areas;
- poor people;
- women;
- people of color;
- teens;
- victims of domestic and sexual violence;
- people without adequate health insurance;
- and other marginalized groups.

The deadline for telling HHS what you think is July 31.

Thank you for speaking up for equal access to health care!

From:	Spottswood, Eleanor
To:	Clark, Charity
Subject:	Title X stats and clinic locations
Date:	Wednesday, July 11, 2018 5:57:46 PM
Attachments:	cyf_TX Needs Assessment 2015.pdf

Charity-

For future reference: this is the most recent document with Vermont-specific Title X data in it. A (rough) map of all the Title X clinic locations is on pdf page 9.

Thanks for your help today!

Ella

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Vermont Title X
Family Planning Needs Assessment

Prepared by JSI Research & Training Institute, Inc. for the
Vermont Department of Health

October 2015

VERMONT
DEPARTMENT OF HEALTH

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Executive Summary

Title X is the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. For more than 45 years, Title X-funded health centers have provided high-quality cost-effective family planning and related preventive health services to low-income, under-insured and uninsured women and men who may otherwise lack access to health care. These health centers play a critical role in ensuring access to voluntary family planning information and services for their clients based on their ability to pay.

The 2015 Vermont Title X assessment process helps to ensure that the state's safety net for sexual and reproductive health services continues to meet the needs of women 15-44 years of age, particularly the most vulnerable. The findings and considerations from the Title X Needs Assessment will guide the Vermont Department of Health (Health Department) and other stakeholders in the planning, programming, and provision of services to ensure a high quality family planning service delivery system that supports Vermont's most vulnerable populations. This report provides a demographic description of Vermont as it relates to family planning, a description of Vermont's Title X family planning system, and a description of Vermont's family planning and reproductive health services and population needs. A summary of the findings and considerations follow.

Vermont Population

- Vermont is one of the most rural states in the U.S., and one of the smallest, with about 626,630 residents in 2013.
- Over 60% of Vermonters live in rural areas of the state. By a large majority, most Vermonters are white (95%), non-Hispanic (98%).
- In 2013, 9% of the Vermont population was under 100% of the federal poverty level (FPL).

Insurance Status

- In 2014, 21% or 132,829 of Vermonters were covered by Medicaid.
- In 2014, about 3.7% or 23,000 Vermonters were uninsured.

Unintended Pregnancy & Teen Pregnancy

- About half of pregnancies among Vermonters are unintended.
- In 2013, the pregnancy rate in Vermont was 61.2 pregnancies per 1,000 women age 15 to 44. The teen pregnancy rate was 21.9 pregnancies per 1,000 women age 15 to 19 years.

Births & Infant Mortality

- In 2013, Vermont had a birth rate of 51.2 births per 1,000 women 15-44 years of age. The teen birth rate was 14.5 births per 1,000 women 15-19 years of age.
- In 2013, Vermont had a preterm birth rate of 8.1%, a low birthweight rate of 7.0%, and an infant mortality rate of 5.0%.

Sexually Transmitted Infections & HIV

- Vermont ranks 44th in rates of syphilis and 46th in rates of both chlamydia and gonorrhea among the 50 states.
- In 2012, the rate of primary and secondary syphilis was 1.0 per 100,000 Vermonters, the rate of chlamydia infections was 275.2 per 100,000 and the rate of gonorrhea was 408.1 per 100,000.
- In 2011, 12 adults and adolescents were diagnosed with HIV in Vermont. Vermont ranked 50th among the 50 states in the number of HIV diagnoses.

Title X in Vermont

The Health Department, the Title X grantee for the state of Vermont, contracts with Planned Parenthood of Northern New England (PPNNE) to provide Title X supported family planning services throughout the state, with a special focus on serving low-income and rural populations.

- In 2013, Title X family planning services helped women in Vermont avoid 2,000 unintended pregnancies, 1000 unplanned births, and 700 abortions, including 400 pregnancies to teens, 200 births to teens, and 100 abortions to teens.
- In 2014, PPNNE's Title X health centers served 7,796 women and 923 men, for a total of 8,719 residents of Vermont.
  - 47% had incomes at or below 100% of the FPL
  - 77% had incomes at or below 250% of the FPL
  - 24% were uninsured
  - 21% were teens under the age of 20, and
  - 11% were men.

- In 2014, 7714 female clients not pregnant or seeking pregnancy were using the following contraceptive methods:
  - 53% Moderately effective hormonal method – pill, patch, ring, Depo
  - 16% Long-acting reversible contraception (LARC) – IUD or implant
  - 3% Permanent sterilization

- In 2014, of the 776 male clients not seeking pregnancy, 65% were using the male condom, 1% vasectomy, 1% withdrawal, and 2% relied on a female method for contraception.

Strengths & Challenges of Vermont's Family Planning Service Delivery System

- Vermont's Title X-funded health centers provide comprehensive, standardized, high-quality, timely and accessible family planning and reproductive health care throughout the state.
- Vermont's expanded Medicaid program and the Access Plan bolster access to family planning services in the state. Vermont has a relatively low proportion of uninsured individuals.
- Vermont has done good work in HIV and sexuality education within schools using research and evidence-based curricula. School Liaisons and school nurses work to coordinate with local parent child centers and providers to support student reproductive and sexual health needs.
- Energy and efforts to improve access to LARC methods in Vermont, specifically within PPNNE's network of health centers, have been successful in promoting use. Remaining challenges exist, including attitudes and beliefs on use of LARC and reimbursement barriers for providing LARC.

- Disparities in unmet family planning need and health outcomes exist in vulnerable population groups throughout the state, including individuals with low income; teens; individuals with mental health and/or substance abuse issues; lesbian, gay, bisexual, transgender and queer population; racial and ethnic minorities; and incarcerated women.

Summary & Considerations

This review of Vermont's family planning system and population needs presents a positive picture overall. The family planning system is thought to have good access with high quality, comprehensive services, and a supportive landscape. In addition to the 10 Title X funded health centers, Vermont has a broad network of safety-net providers supporting the health care needs of residents throughout the state. Key health and reproductive health indicators also present a favorable status for Vermonters. Most all Vermonters now have health insurance and Vermont's infant mortality, preterm birth, and low weight birth rates rank lower than national rates. Furthermore, the teen pregnancy rate and overall fertility rate for Vermont continue to decline while post-partum contraceptive use is high among Vermonters.

Despite these gains, this review indicates remaining challenges for Vermont. The rate of intended pregnancy remains relatively consistent at about 50%, well below the 65% Healthy Vermonters 2020 goal. Furthermore, fewer than half (49%) of mothers whose pregnancies were unintended reported using any method of birth control. Alcohol and tobacco use during pregnancy remain consistently high compared to other states. Several sub-populations of concern were noted as having disparate unmet family planning need due to financial, transportation, and cultural barriers.

In the context of the gains, strengths, and challenges for Vermont's family planning service delivery system, the following focus areas are called out for consideration and intended to guide future efforts of the Health Department and other family planning programs and stakeholders in Vermont.

I. Assess the financial, service delivery, and access implications due to exclusion of the PPNNE Burlington and Williston health center sites from Title X funding.

II. Promote awareness, implementation, and adherence to evidence-based family planning practice guidelines among providers, family planning programs, and health care organizations in Vermont.

III. Explore implementing a quality improvement initiative within hospital systems and/or health care organizations (e.g., FQHCs) throughout the state to promote access to high-quality family planning services with emphasis on the provider's role in family planning and contraceptive counseling.

IV. Continue to explore how to increase access to LARC in a broader way (e.g., beyond PPNNE's heath centers); support innovations and solutions to promote access and awareness of LARC.

V. Facilitate linkages between primary care providers and Title X health centers in Vermont.

VI. Increase provider and consumer knowledge of covered family planning and related preventive health services.

VII. Explore potential opportunities to address family planning, reproductive and sexual health needs of adolescents within school-based health centers in Vermont.

VIII. Explore opportunities for clinical-community linkages between Vermont Title X health centers and community based organizations to establish family planning—human service referral networks.

The considerations are further described on page 25 of the full report.

Introduction

The Title X family planning program is the nation's only dedicated source of federal funding for comprehensive family planning and related preventive health services. The United States Department of Health and Human Services' Office of Population Affairs (OPA) oversees the Title X program and funds a network of family planning centers across the country that serve about five million low-income women and men each year. Services are provided through state, county, and local health departments; community health centers; Planned Parenthood centers; and hospital-based, school-based, faith-based, and other private nonprofits. In addition, Title X is the only federal program that funds critical infrastructure needs not paid for under Medicaid and private insurance, such as staff salaries, patient education, and community education about family planning and sexual health issues. Title X is also used to subsidize health center rent, utilities, and health information technology.

For more than 45 years, the Title X program has supported clinics to provide family planning services and other preventive health care to low-income, under-insured and uninsured individuals who may otherwise lack access to health care. Title X family planning centers play a critical role in ensuring access to voluntary family planning information and services. They provide high quality, culturally-sensitive, and cost-effective family planning and related preventive health services for low-income women and men including a broad range of FDA-approved contraceptive methods and related counseling; as well as breast and cervical cancer screening; pregnancy testing and counseling; screening and treatment for sexually transmitted infections (STIs); HIV testing; and other patient education and referrals.

Title X in a Changing Health Care Environment. Title X, like many large and historical grant programs, was significantly and positively impacted by the passage of the Patient Protection and Affordable Care Act (ACA). ACA put in place comprehensive health insurance reform expanding access to sexual and reproductive health services thus decreasing the likelihood that coverage is the predominant access issue. The law makes preventive care—including family planning and related care—more accessible and affordable for many Americans. With the implementation of the ACA and expansion of Medicaid, more Americans, including Vermonters, will have health insurance, including coverage of a full range of family planning and related preventive services without out-of-pocket costs. As the health care systems in the United States (U.S.) and Vermont reform, Title X-funded health centers will continue to be important safety-net providers, and will continue to serve: individuals who don't qualify for health insurance, underinsured individuals, insured and uninsured individuals where confidentiality cannot be ensured (e.g., adolescents), and individuals who want to continue receiving care at a family planning site.

Additionally, as our health system evolves to expand access to care, initiatives to improve and ensure quality of care are also being implemented. In 2014, the OPA and Centers for Disease Control and Prevention (CDC) released new recommendations called *Providing Quality Family Planning Services*

(QFP).[1] The QFP provides clear evidence-based clinical practice guidelines intended to improve the quality of family planning services and thereby improve reproductive health outcomes. The QFP recommendations: (1) define a core set of family planning services for women and men, including contraceptive services, pregnancy testing and counseling, helping clients achieve pregnancy, basic infertility services, preconception health services, and sexually transmitted disease services; (2) describe how to provide contraceptive and other clinical services, serve adolescents, and conduct quality improvement; and (3) encourage the use of the family planning visit to provide selected preventive health services for women, in accordance with the national recommendations for guideline-based care for women. The QFP recommendations supplement the *Title X Program Requirements*[2] and are intended for all providers of family planning services, in addition to Title X-funded programs. Implementing the QFP clinical guidelines in addition to Title X Program Requirements will help Title X-funded programs improve family planning service delivery and provide the services and supports couples need to achieve their desired number and spacing of children.

Title X-funded health centers serve a fundamental role in providing health care to Vermonters. Compared to other health providers in the state, Title X centers in Vermont are ahead of the curve in providing comprehensive high-quality, guideline-based, culturally competent family planning and reproductive health care. However, there is still room for improvement. The 2015 Vermont Title X assessment process helps to ensure that the state's safety net for sexual and reproductive health services continues to meet the needs of women 15-44 years of age, particularly the most vulnerable. The findings and considerations from the Title X Needs Assessment will guide the Vermont Department of Health (Health Department), policy makers, healthcare providers, health and human service organizations, schools and communities in Vermont in their planning, programming, and provision of services to ensure a high quality family planning service delivery system that supports Vermont's most vulnerable populations. This report provides a demographic description of Vermont as it relates to family planning, a description of Vermont's Title X family planning system and services, and a description of Vermont's family planning and reproductive health services and population needs.

Needs Assessment Process

Vermont's approach to the 2015 Title X Needs Assessment was designed to examine both strengths and needs of the state's family planning service delivery system, and the family planning and reproductive health needs of Vermonters. Additionally, the QFP,[3] which provides recommendations for delivering quality family planning services, was used as a framework to inform the needs assessment and its findings and considerations.

[1] Gavin L, Moskosky S, Carter M, et. al. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. MMMR 2014; 63(No. 4).
[2] Office of Population Affairs. Program Requirements for Title X Funded Family Planning Projects. April 2014.
[3] Gavin L, Moskosky S, Carter M, et. al. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. MMMR 2014; 63(No. 4).

Overall direction for Vermont's 2015 Title X Needs Assessment was provided by the Health Department Director of Preventive Reproductive Health, including input on the assessment process, identification of stakeholders to participate in key informant interviews and group discussion, review of data as well as the development of the final report and considerations. The 2015 Title X Needs Assessment consisted of two primary information gathering processes: (1) review and analysis of public health surveillance data, including secondary quantitative data (e.g., Family Planning Annual Report) and (2) qualitative data collected through a series of key informant interviews and group discussions with Vermont's family planning and maternal and child health (MCH) stakeholders. Stakeholders represented Planned Parenthood of Northern New England (PPNNE), MCH Coordinators, Parent Child Centers, public health professionals, School Liaisons, medical providers, human service providers (e.g. early childhood) and state program administrators. Over 40 stakeholders were identified who then participated in either individual or group discussions with a total of 23 conducted. Interviews and group discussions explored family planning and related preventive health service needs, including needs of vulnerable populations; family planning systems and supports, including quality; strengths and challenges for family planning services; and, opportunities for improvements and/or assets to be leveraged. A complete list of interviewees and interview guides are available in Appendix I.

Vermont's Family Planning Safety-Net

Title X. Vermont has been funded by the Title X program since its inception, with the overarching goal to *provide high quality clinical family planning and related preventive health services, education, and counseling to Vermonters who would otherwise not have access, with a special focus on low-income and rural populations*. The Vermont Department of Health, the Title X grantee for the state of Vermont, contracts with Planned Parenthood of Northern New England (PPNNE) to provide Title X supported family planning services throughout the state. Ten of PPNNE's 12 Vermont health centers are supported with Title X funds; Title X sites are located in Barre, Bennington, Brattleboro, Hyde Park, Rutland, Middlebury, Newport, St. Albans, St. Johnsbury

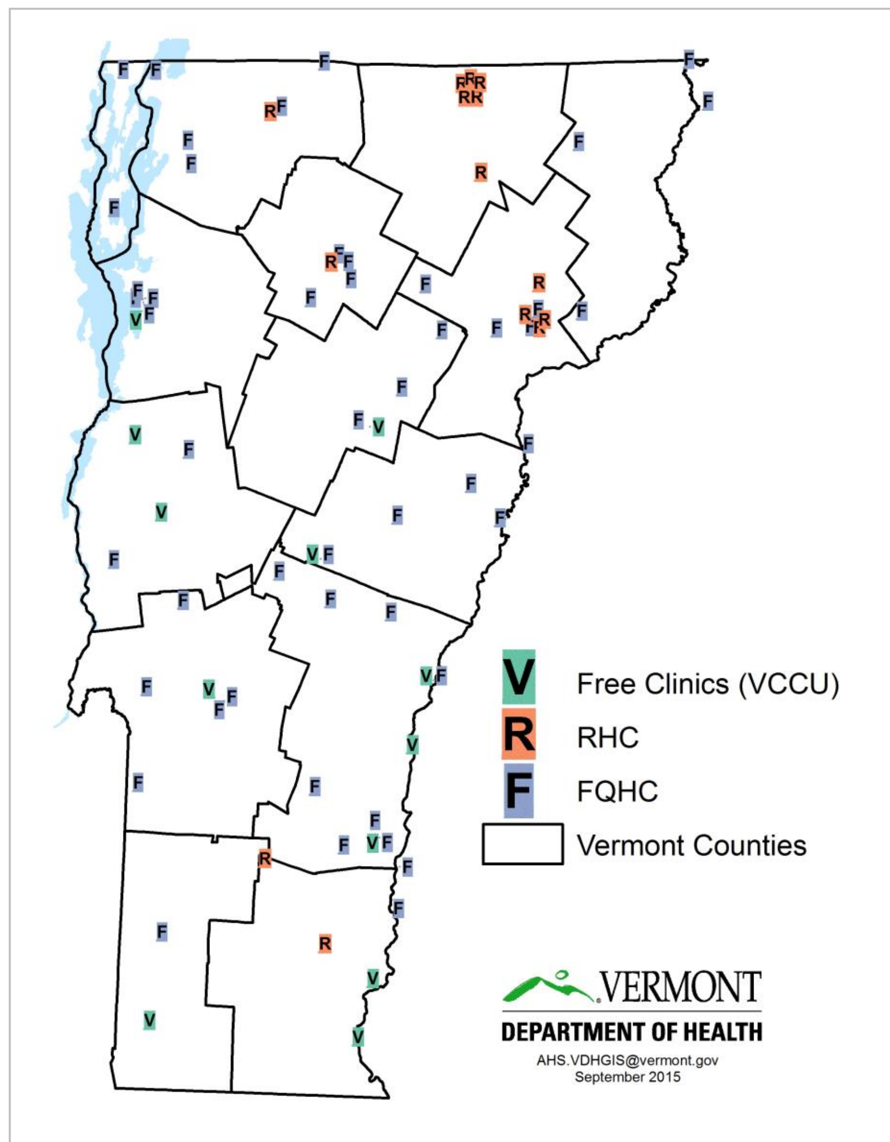
Figure 1. PPNNE Vermont Health Center Sites, 2015

and White River Junction[4] (Figure 1). At present, the PPNNE health centers in Burlington and Williston are not Title X sites. This network of health centers serves as a foundation for providing sexual and reproductive health, and related preventive health services to Vermont's low-income and vulnerable populations.

The state's Title X-funded health centers provide comprehensive family planning and related preventive health services, including contraceptive services; pregnancy testing and counseling; screening, testing, and treatment for sexually transmitted infections; rapid HIV testing; screening for breast, cervical, colorectal, and testicular cancer; preconception education and prenatal referral; basic fertility services; well woman visits; screening for high blood pressure, diabetes and obesity; and referrals for other health and social services. All services provided are based on and adhere to national clinical guidelines and recommendations.

Other Safety-Net Providers. In addition to Vermont's network of Title X health centers, several other organizations and clinics make up Vermont's safety net, including Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), free clinics, and Vermont's hospital system. Across the country FQHCs and RHCs play a critical role in many communities in ensuring access to care for the uninsured and underinsured. FQHCs and RHCs provide primary care in areas designated by the federal government as underserved; and benefit from an enhanced reimbursement for Medicaid and Medicare services.

There are 12 FQHCs and 12 RHCs located throughout Vermont (Figure 2). FQHCs provide comprehensive



[4] The White River Junction health center site is currently funded by New Hampshire's Title X funding.

Figure 2. Vermont healthcare safety-net sites: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Vermont free clinics. 2015

primary care services across the life span. They are organized as a network of clinics or satellites with a central administration. In Vermont, FQHCs have about 50 primary care sites located in 13 of the state's 14 counties.[5] RHCs are only developed in rural areas and specialize in primary care (pediatrics, internal medicine, family practice, obstetrics).

Vermont's network of free clinics adds further strength to the state's safety net system. The Vermont Coalition of Clinics for the Uninsured (VCCU) is the association of 10 organizations serving the needs of Vermonters without adequate medical and dental insurance and without the means to pay for their health care. Six of these clinics provide onsite medical care by volunteer clinician teams, three offer dental care, and four refer patients to available local clinicians. At each clinic, adult patients are screened for eligibility for various public assistance programs including hospital affordable care programs and Medicaid extension programs.[6]

Vermont's hospitals are also an important safety-net provider of the family planning service delivery system. In particular are Vermont's eight critical access hospitals located in rural communities throughout the state and serve as the first line of defense in emergency situations. The critical access hospitals are all non-profit and required by Vermont to provide care to anyone who walks in the door without regard to insurance status or ability to pay.

Other Vermont Resources to Support Family Planning Needs

Other assets in the state intended to support the reproductive and sexual health needs of Vermonters include: "The Access Plan", the Vermont Sexual Health & Education Program (V-SHEP), the Personal Responsibility Education Program or PREP, school-based health centers, and the Department for Vermont Health Access Medicaid Obstetrical and Maternal Support (MOMS) Program.

Nationally and in Vermont, innovative Medicaid-related initiatives are being implemented to increase access to family planning services. In 2012, the Health Department initiated a program with PPNNE branded "The Access Plan". Vermont has not yet implemented the State eligibility option for family planning services and The Access Plan offers the same statewide scope of services for the same population, using funding through Vermont's 1115 Medicaid waiver. This program provides access to free, confidential and convenient family planning services and supplies to men and women in Vermont who have incomes below 200% FPL and are underinsured or uninsured. Eligible individuals can enroll in The Access Plan at any PPNNE health center in Vermont. Covered services include birth control, annual exams, STI testing and treatment, patient education and counseling, and others.

In 2013 Vermont received a CDC grant award called "Promoting Adolescent Health Through School-Based HIV/STD Prevention" to create the Vermont Sexual Health & Education Program (V-SHEP). From 2013-2018 the Agency of Education is working with 15 supervisory unions and school districts throughout Vermont to assist in improving sexual health and education for middle and high school students. There are three main components to this work: providing comprehensive sexual health

[5] Vermont State Office of Rural Health and Primary Care, 2015
[6] Vermont State Office of Rural Health and Primary Care, 2015

education, working with school nurses to ensure all students have a medical home and receive guideline-based preventive pediatric health care, and providing a learning environment in which all students can expect to feel safe and supported. The Agency of Education is partnering with several local and national partners to implement this work including Outright Vermont in Burlington, The Center for Health and Learning in Brattleboro, and Answer, which is a national sexual education organization.

In 2011, the Health Department was awarded a Personal Responsibility Education Program (PREP) grant to support comprehensive education on sexual health, abstinence, and contraception for the prevention of pregnancy and sexually transmitted infections (STIs). The program targets youth between ages 10-19 who are homeless, in foster care, live in rural areas or in geographic areas with high teen birth rates, or come from racial or ethnic minority groups. The program also supports pregnant and parenting youth under 21 years of age. The Health Department is currently funding six community-based organizations throughout the state to implement PREP; PREP is offered at 13 sites across the state and will serve approximately 440 youth in the 2015 grant year.

School-based health centers (SBHC) have become an important method of health care delivery for youth throughout the country. They provide a variety of health care services to youth in a convenient and accessible environment. Although SBHC models vary, they are typically operated as a partnership between the school and a community health organization, such as a community health center. The services provided by SBHCs vary based on community needs and resources as determined through collaborations between the community, the school district and the health care providers. Currently, there are about five SBHCs in Vermont, including in Burlington High School and in St. Albans. The structure of SBHCs in Vermont varies depending on need and they are intended to supplement rather than replace the medical home. They assure the provision of key physical and mental health services as well as preventive health services.

The MOMS Program is administered through the Vermont Chronic Care Initiative (VCCI) at the Department of Vermont Health Access. The goal of this program is to improve pregnancy outcomes for Medicaid covered pregnant women considered high risk due to a mental health condition, substance use, and/or having had a previous pre-term delivery prior to 32 weeks gestation. Them MOMS Program provides enhanced prenatal care that includes a comprehensive psychosocial assessment, care coordination, an individualized maternity care plan, and referral to other social support services and resources that may result in improved pregnancy outcomes.

Vermont Geographic, Demographic & Socioeconomic Overview

Geography. Vermont is one of the most rural states in the U.S., and one of the smallest, with a population estimate of 626,630 in 2013.[7] Vermont has only one true urban area (i.e. metropolitan statistical area) comprised of Chittenden, Franklin, and Grand Isle counties. Over 60% of Vermont's population resides in rural areas.[8]

Demographics. In 2013, Vermont's population distribution by age was estimated as follows:[9]

- 19.6% children 0-17 years of age
- 33.8% adults 18-44 years of age
- 30.2% adults 45-64 years of age
- 16.4% 65 years of age and older

About 51% of Vermont's population is female.[10]

Although Vermont's racial and ethnic minority populations are growing, the large majority of Vermonters are white. In 2013, the population distribution by race and ethnicity was estimated as follows:[11]

- 95.2% White
- 1.2% Black or African American
- 0.4% American Indian and Alaska Native
- 1.4% Asian
- 1.8% Multiracial
- 1.7% Hispanic or Latino

Vermont's largest urban area, Chittenden County, is composed of greater racial and ethnic diversity compared to the state:[12]

- 92.2% White
- 2.3% Black or African American
- 0.3% American Indian and Alaska Native
- 3.2% Asian
- 2.0% Multiracial
- 2.0% Hispanic or Latino

Employment. Since July 2013, the Vermont economy has been steadily improving. As of May 2015, Vermont's unemployment rate was 3.6%, compared to a national rate of 5.5%. However, the

[7] Vermont Department of Health. Vermont Population Estimates 2013.
[8] Census Bureau. Growth in Urban Population Outpaces Rest of Nation, Census Bureau Reports. March 26, 2012. https://www.census.gov/newsroom/releases/archives/2010_census/cb12-50.html Accessed June 26, 2015.
[9] Vermont Department of Health. Vermont Population Estimates 2013.
[10] Vermont Behavioral Risk Factor Surveillance System. 2014 Data Summary.
[11] Census Bureau. Quick Facts Vermont. Accessed August 11, 2015.
[12] Census Bureau. Quick Facts Vermont. Accessed August 11, 2015.

unemployment rate varies across counties, ranging from 2.5% in Chittenden County and 5.7% in Essex county, and across towns, ranging from 1.9% in Middlesex up to 17.3% in Killington.[13]

Income. In 2014, Vermont's average annual wage was $43,011, with higher wages in Chittenden County at $49,656 and the lowest wages in Grand Isle County at $31,111.[14] According to the 2014 federal poverty guidelines, an income of $23,850 for a family of four is equal to the federal poverty level (FPL).[15]

Poverty. In 2013, 9% of the Vermont population was under 100% FPL compared to 15% of the U.S. population;[16] and 19% of the Vermont population fell between 100%-199% FPL, equivalent to the U.S. population.[17]

Education. About 91% of Vermonters age 25 and older are high school graduates, compared to 86% of the U.S. population.[18] Just over three in ten (32%) Vermont adults have a college education or higher; four in ten or 39% have a high school education or less.[19]

Insurance Status. Children 0-18 years of age with a family income of 312% FPL are eligible for Medicaid in Vermont. Women who are pregnant with an income up to 208% FPL are eligible for Medicaid in Vermont. Vermont has expanded Medicaid coverage to low-income adults as well, up to 133% FPL.[20] In 2014, 21% or 132,829 Vermonters were insured by Medicaid.[21]

In 2014, it was estimated that 3.7% or 23,000 Vermonters were uninsured. Compared to 2012, the number of Vermont residents reporting no health insurance decreased by about 20,000 individuals (6.8% to 3.7%). About 1,300 of Vermont's uninsured population are under age 18, representing 1% of Vermont's children 0-17 years of age. About 2,900 or 4.6% of young adults 18-24 are uninsured and about 7,900 or 11% of adults 25-34 years of age are uninsured.[22]

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[13] Vermont Department of Labor. Local Area Unemployment Statistics. May 2015.
[14] Vermont Department of Labor. Vermont Quarterly Census of Employment Wages. 2014.
[15] U.S. Department of Health and Human Services. 2014 Federal Poverty Guidelines.
[16] The U.S. Census Bureau's poverty threshold for a family with two adults and one child was $18,751 in 2013.
[17] The Henry J. Kaiser Family Foundation. State Health Facts, Vermont. www.statehealthfacts.org
[18] Census Bureau. Quick Facts Vermont. Accessed June 26, 2015.
[19] Vermont Behavioral Risk Factor Surveillance System. 2014 Data Summary.
[20] Medicaid.gov. Vermont Profile. Accessed September 9, 2015.
[21] Vermont Department of Financial Regulation, Insurance Division. 2014 Vermont Household Health Insurance Survey Research Findings.
[22] Vermont Department of Financial Regulation, Insurance Division. 2014 Vermont Household Health Insurance Survey Research Findings.

Vermont Family Planning & Reproductive Health Overview

Women of Reproductive Age. In 2013 in Vermont, there were 116,335 women of reproductive age (aged 15–44).[23] According to Vermont's Behavioral Risk Factor Surveillance System (BRFSS), a telephone survey conducted annually among adults 18 and older, in 2013:[24]

- 36% of women age 18-44 said a health care professional had ever spoken with them about ways to prepare for a healthy pregnancy and baby.
- 72% of women 18-44 said they used birth control at the last time they had sex. More than a third (36%) said it was a shot, pill, contraceptive patch or a diaphragm; 22% used a permanent method (i.e., sterilization); and 17% used a LARC.
- Women who did not use birth control during their most recent sex indicated most often it was because they were unable to get pregnant (43%) or they were seeking pregnancy (26%).

Births. In 2013, 5,951 babies were born to Vermont residents, representing a birth rate of 51.2 births per 1000 women 15-44 years of age (i.e., fertility rate), a slight decrease from 51.5 in 2012 and 51.6 in 2011. The teen birth rate in Vermont in 2013 was 14.5 births per 1000 women 15-19 years of age, compared to the U.S. rate of 26.5; 317 infants were born to Vermont mothers ages 15-19 in 2013.[25]

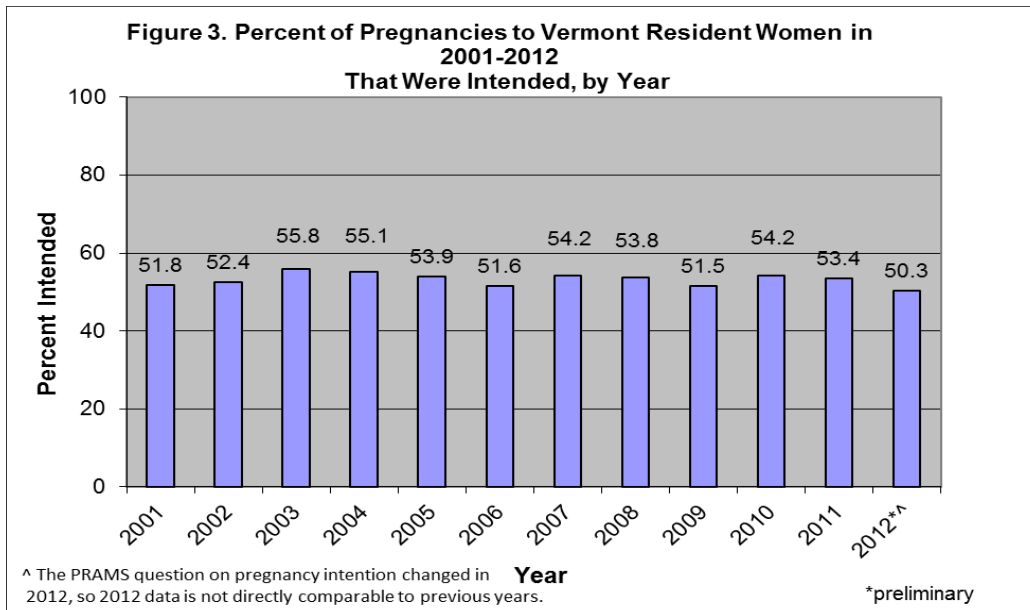
Vermont's preterm birth rate in 2013 was 8.1% compared to 11.4% among the U.S. population. Vermont's low birthweight rate in 2013 was 7% compared to 8% among the U.S. population. Vermont's infant mortality rate was 5.0% compared to 6.4% among the U.S. population.[26]

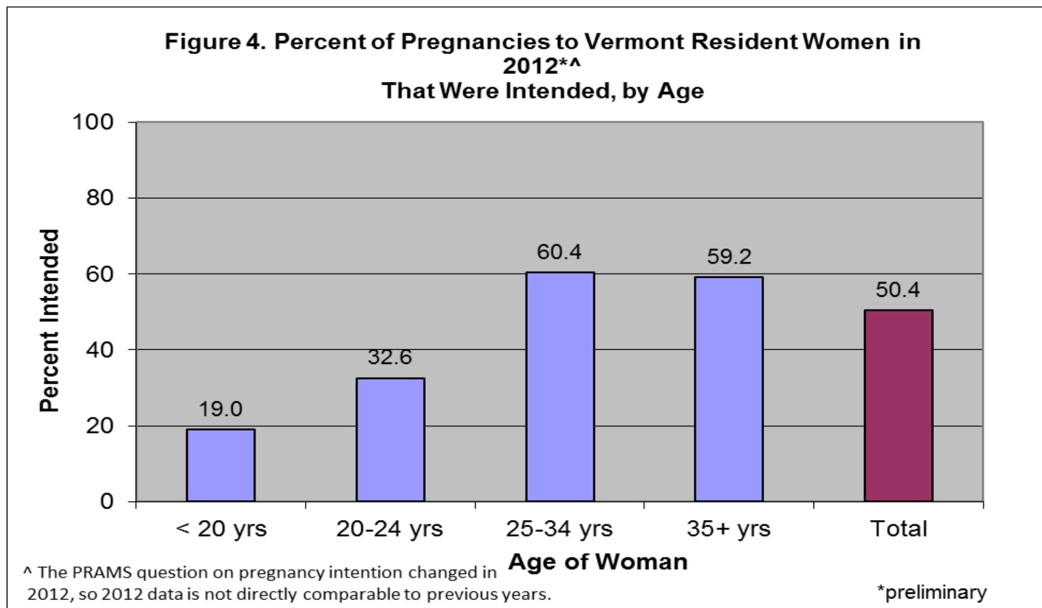
Pregnancy & Unintended Pregnancy. In 2013, the pregnancy rate in Vermont was 61.2 pregnancies per 1,000 women age 15 to 44, a decrease from 61.7 in 2012 and 62.4 in 2011. The 2013 teen pregnancy rate was 21.9 pregnancies per 1,000 women age 15 to 19 years, a decrease from 23.1 in 2012 and 25.2 in 2011. In general the teen pregnancy rate has been decreasing since 1991.[27]

Unintended Pregnancy. The Pregnancy Risk Assessment Monitoring System (PRAMS) helps public health professionals survey the population and track trends over time. The survey is of women who recently gave birth and asks about their experiences and behaviors before, during and shortly after their pregnancy. In 2012, PRAMS indicated that 39.8% of pregnancies among Vermont women who had a live birth were unintended. This is an increase from 2010 and 2011, in which 35.1% and 35.4% of Vermont pregnancies were reported as unintended, respectively. However, of note is a change in the 2012 PRAMS survey question on the intendedness of a pregnancy. The 2012 respondents were given the option of responding to the question with "I wasn't sure what I wanted". This answer option is included as unintended and therefore 2012 data are not directly comparable to previous years.[28]

[23] Vermont Department of Health. Vermont Population Estimates 2013.
[24] Vermont Behavioral Risk Factor Surveillance Survey. 2013 Data Summary.
[25] Vermont Department of Health. Vital Statistics. Internal Communication and 2011 Vital Statistics Report.
[26] The Henry J. Kaiser Family Foundation. State Health Facts, Vermont. www.statehealthfacts.org
[27] Vermont Department of Health. Vital Statistics. Internal Communication.
[28] Vermont Department of Health. Pregnancy Risk Assessment Monitoring System. Internal Communication.

Using PRAMS data to estimate the percentage of women with live births who report their pregnancy was intended and applying this to Vermont's vital statistics data on the number of pregnancies, live births, and abortions (considered unwanted pregnancies), intended pregnancies among Vermont women can be further analyzed. Figure 3 displays the percent of pregnancies to Vermont women that were intended, by year, and Figure 4 displays the percent of pregnancies to Vermont women in 2012 that were intended, by age. According to 2012 data, 50.4% of pregnancies to Vermont women were intended relative to the Healthy Vermonters 2020 goal of 65%.[29]





[29] Vermont Department of Health. Pregnancy Risk Assessment Monitoring System and Vital Statistics.

Teen Sexual Behavior, Pregnancy & Birth Rate. In 2013, 43% of high school students in Vermont reported ever having sex and 44% reported ever having oral sex. Among those sexually active, 85% reported using prescription birth control or condoms at last sex. Twenty two percent of students reported using drugs or alcohol at last sex.[30]

Vermont has a relatively low teen pregnancy rate of 22 pregnancies per 1000 women 15-19 years of age, a decrease from 23.1 in 2012 and 25.2 in 2011. In 2013, there were 478 pregnancies to Vermont teens aged 15–19; 317 or 66% resulted in a live birth. Based on this data, the 2013 teen birth rate is 14.5 per 1,000 women 15-19 years of age, a decrease from a rate of 16.3 in 2012 and 16.8 in 2011.[31]

STIs & HIV.

Syphilis [32]

- In Vermont, the rate of primary and secondary syphilis was 1.8 per 100,000 in 2008 and 1.0 per 100,000 in 2012. Vermont ranks 44th in rates of syphilis among the 50 states.
- There were 0 cases of congenital syphilis from 2008 through 2012.

Chlamydia & Gonorrhea[33]

In 2012, Vermont:

- Ranked 46th among 50 states in chlamydial infections (275.2 per 100,000 persons) and ranked 46th among 50 states in gonorrheal infections (15.8 per 100,000 persons).
- Reported rates of chlamydia among women (408.1 cases per 100,000) were 2.9 times greater than those among men (138.6 cases per 100,000).

HIV

- In 2011, an estimated 12 adults and adolescents were diagnosed with HIV in Vermont. Vermont ranked 50th among the 50 states in the number of HIV diagnoses in 2011. [34]
- In 2014, 3 in 10 (31%) of Vermont adults reported every being tested for HIV, with more than half indicating their last HIV test was at a private doctor's office. Adults 25-44 were significantly more likely to have ever been tested for HIV (52%) than other age groups. Six percent of Vermont adults reported HIV testing in the past year.[35]

Family Planning Behaviors & Risk Factors. Understanding family planning behaviors and risk factors that affect reproductive and sexual health help to identify opportunities for prevention, early intervention, and education, particularly for those who experience an unintended pregnancy. The following information is from the 2011 Vermont PRAMS:[36]

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[30] Vermont Youth Risk Behavior Survey. 2013.
[31] Vermont Department of Health. Vital Statistics. Internal Communication and 2011 Vital Statistics Report.
[32] CDC. Vermont—2013 State Health Profile. http://www.cdc.gov/nchhstp/stateprofiles/pdf/Vermont_profile.pdf Accessed July 9, 2015.
[33] CDC. Vermont—2013 State Health Profile. http://www.cdc.gov/nchhstp/stateprofiles/pdf/Vermont_profile.pdf Accessed July 9, 2015.
[34] CDC. Vermont—2013 State Health Profile. http://www.cdc.gov/nchhstp/stateprofiles/pdf/Vermont_profile.pdf Accessed July 9, 2015.
[35] Vermont Behavioral Risk Factor Surveillance System. 201.
[36] Vermont Pregnancy Risk Assessment Monitoring System. 2011.

- Half (49%) of mothers whose pregnancies were unintended reported using any method of birth control.
- Vermont has a relatively high rate of postpartum contraception use compared to other PRAM states; 88% of mothers used contraception after their most recent birth, including 95% of teen mothers.
- Although the Vermont PRAMS survey found a discussion with a health care worker about birth spacing was not associated with the likelihood of using contraception, postpartum contraception use occurred more frequently with women who had talked to a health care worker about a specific method of birth control after delivery. The most common reasons women gave for not using postpartum contraception were abstinence and "don't want to use".

Vermont 2011 PRAMS data indicate the following regarding preconception health:

Multivitamin Use and Weight Gain: 38% of women reported taking a multivitamin every day in the month prior to pregnancy; 19% of mothers age 20 - 24 took a daily multivitamin during the month prior to pregnancy. 23% of mothers were overweight prior to pregnancy, and 20% were obese. 29% of mothers were dieting to lose weight in the year prior to pregnancy, and over half (52%) reported exercising 3 or more times per week.[37]

Alcohol and Tobacco Use: 31% of women smoked in the three months prior to pregnancy; 19% smoked during the last trimester. 67% of women reported drinking at least some alcohol in the 3 months prior to pregnancy; and, 13% of women reported drinking during the last 3 months of their pregnancy, the highest rate reported among states with PRAMS data.[38]

Stress and Abuse: 70% of women reported at least one stressor during the year before giving birth, with 27% reporting at least 3 stressors, and 6% reporting 6 or more.[39]

- 53% reported financial stress
- 29% reported experiencing emotional stress
- 28% reported partner stress
- 20% reported traumatic stress

Intimate Partner Violence. The 2014 Vermont BRFSS survey included questions on intimate partner violence. Responses indicate that 13% of adults said an intimate partner had ever hit, slapped, pushed, kicked or hurt them in any way. Having ever experienced physical abuse by an intimate partner was statistically more common among women at 16% compared to 9% of men. Additionally, 12% of adults said an intimate partner had ever threatened or made them feel unsafe in some way, and 13% said that an intimate partner had ever tried to control their daily activities. These experiences

[37] Vermont Pregnancy Risk Assessment Monitoring System. 2011.
[38] Vermont Pregnancy Risk Assessment Monitoring System. 2011.
[39] Vermont Pregnancy Risk Assessment Monitoring System. 2011.

were also statistically more common among women compared to men, 19% versus 5% and 16 versus 9%, respectively.[40]

Impact of Services Provided by Title X

- In 2013, there were 68,060 women in Vermont in need of *publicly supported* contraceptive services and supplies. Of these, 9,830 were in need of publicly supported services because they were sexually active teenagers and 26,030 because they had incomes below 250% FPL.[41]
- In 2013, Title X family planning services helped women in Vermont avoid 2,000 unintended pregnancies, 1000 unplanned births, and 700 abortions, including 400 pregnancies to teens, 200 births to teens, and 100 abortions to teens.[42]

Vermont's Title X Population

In 2014, PPNNE's Title X network of health centers served 7,796 women and 923 men, for a total of 8,719 residents of Vermont,[43] compared to a total of 8,872 served in 2013.[44] Of the 8,719 clients served in 2014:

- 47% had incomes at or below 100% FPL, 77% had incomes at or below 250% FPL
- 24% were uninsured
- 21% were teens under the age of 20, and
- 11% were men

The following tables further describe the 8,719 Vermont residents served by Title X in 2014.[45]

Table 1. Unduplicated Number of Family Planning Users by Age Group and Sex

Age Group	Female Users	Male Users	Total Users (%)
Under 15	96	4	100 (1%)
15 – 17	799	24	823 (9%)
18 – 19	871	49	920 (11%)
20 – 24	2193	286	2479 (28%)
25 – 29	1556	207	1763 (20%)
30 – 34	899	171	1070 (12%)
35 – 39	521	65	586 (7%)
40 – 44	376	50	426 (5%)
Over 44	485	67	552 (6%)
Total Users	7796	923	8719

[40] Vermont Behavioral Risk Factor Surveillance System. 2014.
[41] Frost JJ, Frohwirth L and Zolna MR, Contraceptive Needs and Services, 2013 Update, New York: Guttmacher Institute, 2015.
[42] Frost JJ, Frohwirth L and Zolna MR, Contraceptive Needs and Services, 2013 Update, New York: Guttmacher Institute, 2015.
[43] Vermont Title X Family Planning Annual Report. Preliminary Data 2014.
[44] Vermont Title X Family Planning Annual Report. 2013.
[45] Vermont Title X Family Planning Annual Report. Preliminary Data 2014.

Table 2. Unduplicated Number of Family Planning Users by Race and Ethnicity

Race	Hispanic or Latino	Not Hispanic or Latino	Unknown/ Not Reported	Total Users (%)
American Indian or Alaska Native	0	11	1	12 (<1%)
Asian	0	44	5	49 (<1%)
Black or African American	5	91	12	108 (1%)
Native Hawaiian or Other Pacific Islander	0	3	0	3 (<1%)
White	63	5109	465	5637 (65%)
More than one race	7	29	4	40 (<1%)
Unknown/not reported	70	2533	267	2870 (33%)
Total Users	145	7820	754	8719

Table 3. Unduplicated Number of Family Planning Users by Income Level

Income Level as a Percentage of the HHS Poverty Guidelines	Number of Users (%)
100% and below	4110 (47%)
101% - 150%	1275 (15%)
151% - 200%	885 (10%)
201% - 250%	433 (5%)
Over 250%	929 (11%)
Unknown / Not Reported	1087 (12%)
Total Users	8719

Table 4. Unduplicated Number of Family Planning Users by Principal Health Insurance Coverage Status

Principal Health Insurance Covering Primary Medical Care	Number of Users (%)
Public Health Insurance	3342 (38%)
Private Health Insurance	3278 (38%)
Uninsured	2099 (24%)
Unknown / Not Reported	0
Total Users	8719

Contraceptive Methods Used. PPNNE health centers provide contraceptive counseling to all clients as part of a family planning visit and/or for all clients at risk for pregnancy. In 2014, 7714 female clients not pregnant or seeking pregnancy were using the following contraceptive methods:[46]

- 53% Moderately effective hormonal method – pill, patch, ring, Depo
- 16% Long-acting reversible contraception (LARC) – IUD or implant
- 3% Permanent sterilization
- 3% Abstinence

Table 5. Unduplicated Number of Female Family Planning Users by Primary Method of Contraception

Primary Contraceptive Method	Total Female Users
Female Sterilization	235
Intrauterine Devise or System	797
Hormonal Implant	445
Hormonal Injection	726
Oral Contraceptive	2918
Contraceptive Patch	139
Vaginal Ring	311
Cervical Cap or Diaphragm	8
Contraceptive Sponge	0
Female Condom	7
Spermicide (used along)	5
Fertility Awareness or Lactational Amenorrhea Method	0
Abstinence	206
Withdrawal or other method	74
Rely on Male Method	
Vasectomy	37
Male Condom	543
No Method	854
Unknown/Not Reported	409
Total Female Users	7714

Similar to national trends, LARC use among Vermonters is growing, particularly among women served by Title X clinics in Vermont. In 2010, 7.2% of the females served by Title X clinics and using contraception reported a LARC as their primary method of contraception. In 2014, LARC use grew to 17.5% among females served by Title X clinics and using contraception (Figure 5.)[47]

[46] Vermont Title X Family Planning Annual Report. Preliminary Data 2014.

[47] Vermont Title X Family Planning Annual Report. 2010 -2013; Preliminary Data 2014. Denominator excluded female clients reporting pregnant or seeking pregnancy, refraining from sexual intercourse, and whose primary method was unknown.

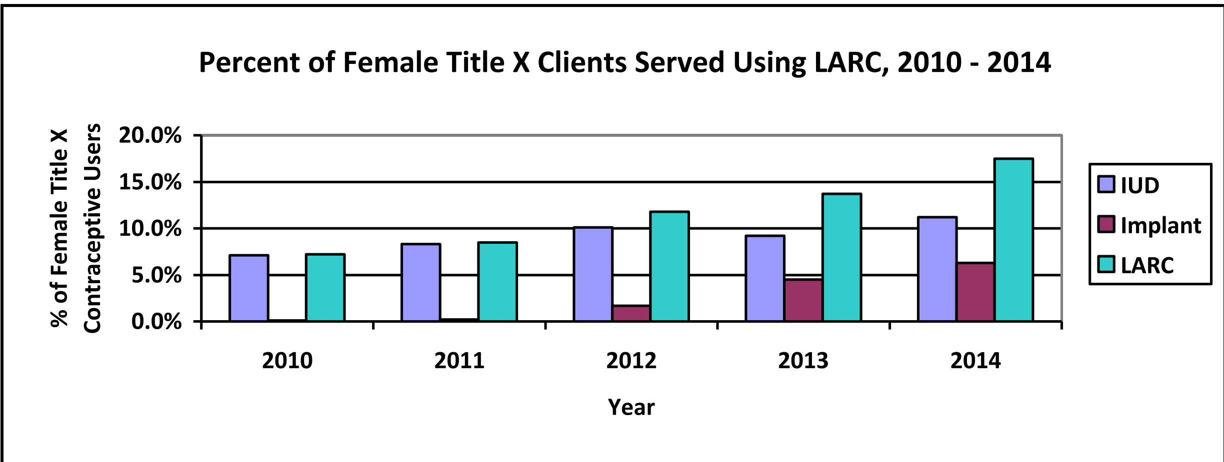

Figure 5. Percent of Title X Female Family Planning Users Reporting use of LARC, 2010 –2014.

In 2014, the 776 male clients not seeking pregnancy were using the following contraceptive methods:[48]

- 65% Male condom
- 1% Vasectomy
- 1% Withdrawal
- 2% Rely on female method

Table 6. Unduplicated Number of Male Family Planning Users by Primary Method of Contraception

Primary Contraceptive Method	Total Male Users
Vasectomy	7
Male Condom	508
Fertility Awareness Method	0
Abstinence	41
Withdrawal or other method	10
Rely on Female Method	14
No Method	136
Unknown/Not Reported	60
Total Male Users	776

STI & HIV Testing. PPNNE provides evidence-based STI screening, testing, and counseling. In 2014, PPNNE Vermont Title X health centers performed the following tests:

- 5,281 Chlamydia tests
- 5,283 Gonorrhea tests
- 1,544 HIV tests
- 403 Syphilis tests

[48] Vermont Title X Family Planning Annual Report. Preliminary Data 2014.

- 1030 HSV tests
- 1544 rapid HIV tests

Furthermore, 60% of all female patients under 25 years of age received a chlamydia test in 2014.

Preventive Health Services. In 2014, 15% of all female clients received a Pap test for cervical cancer screening and 24% received a clinical breast exam.[49]

Findings from the Field

To assess the strengths, challenges, and needs of Vermont's family planning service delivery system, with a particular focus on Title X-funded health centers and services, key informant interviews and discussion groups were conducted with organizations and stakeholders such as PPNNE (e.g., Medical Director, Senior Operations Manager, Director of Government Grants); Vermont's Primary Care Public Health Integration group, Department for Vermont Health Access, and School Liaisons from Vermont's Office of Local Health. A summary of findings and themes related to quality, access, needs, and high priority populations is provided.

Strengths of Vermont's Family Planning System. As the sole Title X provider in Vermont, PPNNE is a valued asset in the state, according to interviewees. PPNNE interviews indicated they provide comprehensive, standardized, high-quality family planning and reproductive health care across all of their health centers throughout the state. To ensure accessible and timely services, health center sites are maintained regionally throughout the state. As a result, access to PPNNE's services is considered strong, even in the very rural parts of the state. Vermont's Medicaid program and the Access Plan further bolster access to family planning services, according to interviewees. The Medicaid income eligibility limit for Vermont adults is 138% FPL and 213% FPL for women who are pregnant.[50] For children 0-18, the Medicaid income eligibility limit is set at 242% FPL and 317% FPL for the Children's Health Insurance Program (CHIP).[51] The Access Plan, sponsored by the Health Department, supports PPNNE's delivery of family planning services to low-income Vermonters living at less than 200% FPL. Interviewees were optimistic that as health care reform is implemented in Vermont, there will increasingly be more people with access to private health insurance and have no cost-sharing for most of the services PPNNE provides (i.e. preventive services).

Vermont has a relatively low number and proportion of uninsured individuals compared to other states and as more become insured, PPNNE expects it will benefit from a business perspective because there will be fewer men and women to cover via a sliding fee. As the health care system in Vermont evolves in response to health care reform, interviewees indicated a need to establish the role of family planning within the strategies for improved population health, which currently focuses on chronic conditions. Interviewees have found it challenging to weave family planning strategies (e.g., LARC) into health reform conversations that focus on exploring high impact opportunities to promote

[49] Vermont Title X Family Planning Annual Report. Preliminary Data 2014.
[50] The Henry J. Kaiser Family Foundation. State Health Facts, Vermont. www.statehealthfacts.org
[51] The Henry J. Kaiser Family Foundation. State Health Facts, Vermont. www.statehealthfacts.org

preventive care and wellness as a mechanism to improve overall population health. One challenge noted is conveying the long-term shared savings from family planning interventions relative to providers being limited to capturing savings from attributable patients. As one interviewee noted, "…the savings needs to be shared more broadly". It was suggested that accountable communities of health may be an opportunity to better address the health impact and savings of family planning strategies within the context of improving population health while reducing costs to the health care system.

To ensure accessible high-quality systems and services, PPNNE shared that they have established practices to monitor, assess and improve their clinical and administrative workflows, workforce capacity, and better address patient needs. Specific initiatives include:

- Transitioning all health centers to an electronic health record system (EHR), with a final rollout to be complete by September 2015.
- Enhanced staffing models (e.g., Health Care Associates), flexible staffing (e.g., telecommute), and telemedicine initiatives (e.g., contraceptive counseling and options, urinary tract infection visit, and STI/HIV screening) to maximize capacity, and to support a feasible and financially sustainable business model, high-quality staffing and retention, and a work environment supportive of work-life balance.
- Rebranding of all health centers to have an aligned look and feel that speaks to the quality of care PPNNE provides. This initiative is intended to support a change in PPNNE's tagline to a provider of choice rather than a provider of last resort. The rebranding initiative is expensive and has been supported by private donations to date.
- Efforts to ensure culturally competent care, such as recruiting a diverse workforce representative of the patient population PPNNE serves, and providing ongoing training of staff to increase culturally competent care (e.g., PPNNE human resources Inclusivity Project).
- Strategic collaboration with community partners to best serve the needs of vulnerable populations (e.g., maintain same day access to services at the St. Albans health center to support needs of population with substance abuse issues).
- Addition of a centralized nurse care coordinator to provide care coordination for clients across PPNNE Vermont health centers and other primary care or specialty providers.

Other strengths reported beyond the Title X funded health centers focused on schools and potential for SBHCs to address sexual and reproductive health. Interviewees reported that Vermont has done good work in HIV and sexuality education within schools using research and evidence-based curricula. PREP and V-SHEP are examples. School Liaisons and school nurses throughout the state make efforts to coordinate with local parent child centers and providers to support students' reproductive and sexual health needs. For example, in Brattleboro the School Liaison makes efforts to coordinate with the local PPNNE health center to facilitate student contraceptive needs; in Morrisville the Coordinated School Health Team is currently focusing on sexuality education across grades K-12. Building on this work, interviewees feel there is further need and opportunity to do more systems-level work to address barriers (e.g., transportation, financial, and attitudes and beliefs on providing sexual and reproductive health education and services within the school setting), and to create linkages between schools, communities, and health care providers in support of student health, including reproductive and sexual health. Interviewees suggested the *Whole School, Whole Community, Whole Child* model

is an opportunity to address student reproductive and sexual health more broadly within schools and communities, as this model emphasizes collaboration among the school, health, and community sectors to improve each child's learning and health.[52]

SBHCs were also noted as strength where they exist in the state. Some health care providers have looked at how SBHCs could provide services for specific areas of need in concert with primary care providers. Burlington High School has a SBHC in which primary care providers see students at the SBHC for acute visits. The providers are currently working more on connecting students with primary care for regular routine visits, such as adolescent health visits. However, providers noted that not all students are receptive to following up with a primary care provider or medical home, and therefor there is need to provide primary care services to students at the SBHC (e.g., vaccines).

The SBHC in St. Albans was indicated as a long-standing example of a SBHC in which a local community provider goes to the high school once a week to see patients to provide health services such as followup on asthma and depression. In Burlington's SBHC, providers find that mental health and behavioral health issues are the most prevalent issues they address with students. Providers work closely with the guidance counselors and the Community Health Team to support student counseling needs. Reproductive health and sexual health services are not currently provided by SBHCs, according to those interviewed.

Challenges for Vermont's Family Planning System. Although PPNNE has implemented several innovative strategies to enhance access to services throughout the state and to target populations, interviewees feel there is room for improving access. They reported that maintaining access in the very rural areas of the state has been difficult due to challenges related to financial sustainability and staff recruitment and retention. Thus, some of PPNNE Vermont health centers are very small and open on a limited basis (e.g., fewer hours and/or days per week).

Interviewees are interested in improving access to services for teens, particularly for teens insured under their parents' health care plans but who may be reluctant to use their insurance due to concerns about confidentiality.

Gaps in access to family planning services were reported for other vulnerable populations in Vermont as well, such as the immigrant and migrant populations, both due to barriers in access related to lack of insurance and barriers related to outreach, engagement, transportation, and health literacy.

Interviewees reported there are gaps in the system on engagement and access for individuals with substance abuse issues. Although PPNNE health centers and community based organizations are making efforts to better reach these individuals to meet their family planning needs, they find it is a difficult population to reach as family planning is often a secondary priority relative to substance use and treatment.

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[52] Centers for Disease Control and Prevention. Whole School, Whole Community, Whole Child. http://www.cdc.gov/healthyyouth/wscc/ Accessed October 2, 2015.

Long-Acting Reversible Contraception (LARC). Interviewees felt strongly that increasing awareness, access, and availability to long-acting reversible contraception (LARC) is a key strategy to reducing unintended pregnancy. LARC includes intrauterine devices (IUD) and implants, which are highly effective contraceptive methods for preventing pregnancy. Energy and efforts to improve access to LARC in Vermont, specifically within PPNNE's network of health centers, are felt to have been successful in promoting use of LARC. Interviewees reported the following initiatives have been important factors in improving access and uptake of LARC over recent years:

- All PPNNE clinicians are trained to provide LARC
- A centralized supply chain for LARC ensures adequate supplies at each site to provide same-day services as needed
- Bulk purchase of LARC supports affordability
- Establishing referral relationships and processes with other providers to support access to LARC
- Tiered counseling for all patients promotes awareness and uptake of LARC
- Establishment of a LARC Workgroup (e.g., Health Department, PPNNE, Primary Care Public Health Integration group members, UVM Medical Center Departments of Obstetrics and Gynecology and Family Medicine, and VCHIP)
- Conducting a needs assessment, provider survey and mapping of LARC services in Vermont to inform LARC training to providers. Training will be provided by the Vermont Child Health Improvement Program, a maternal and child health services research and quality improvement program of the University of Vermont.

Remaining barriers and challenges to promoting access and use of LARC were identified and include addressing (1) misperceptions, attitudes, and beliefs on LARC, and (2) the low margins of reimbursement most providers realize for providing LARC, which lends to low financial incentive for promoting provision of LARC. One emerging solution noted to reduce the financial burden of providing LARC is a new alternative IUD, Liletta. PPNNE reported that Liletta is recently available at an improved pricing structure for Title X grantees and FQHCs. PPNNE has replaced the Mirena IUD with Liletta to ease the financial burden of stocking and providing these devices.

Another reported barrier to expanding access to LARC post-partum is the bundled reimbursement mechanism for providing an IUD. In general, both public and private insurers have a global reimbursement rate for hospital care and services during the time of delivery. Provision of LARC post-partum after delivery is included in this bundled rate, resulting in a financial loss to hospitals that provide an IUD post-partum.

As Vermont works to expand access to LARC, particularly for adolescents, interviewees feel that strengthening relationships and referrals from the pediatric community will be important. Interviewees feel the pediatric community is currently not comfortable with providing LARC. PPNNE feels their well-established systems and skilled workforce could serve as an important resource to meet the LARC need among interested Vermont adolescents. In addition to relationship building, it is felt that culture change regarding the perception and role of PPNNE health centers among the medical community will be necessary to facilitate collaborative agreements and referral networks.

The Community Health Centers of Burlington, an FQHC, noted they too have strong systems in place to provide LARC. Staff are trained to provide LARC, including mid-level providers, they stock LARC supplies, and have found they have good uptake of LARC among their patient population.

High Priority Populations. Interviewees noted several populations in Vermont they prioritized as vulnerable and in need of family planning services. These included individuals of low income; teens; men; individuals with mental health and/or substance abuse issues; the lesbian, gay, bisexual, transgender and queer population (LGBTQ); racial and ethnic minorities; and women who are incarcerated.

Low Income. Interviewees indicated that PPNNE health centers serve clients across all incomes, but the majority of their clients are of low income, at or below 100% FPL. Interviewees expressed concern around fully meeting the many social needs of low income clients, which can also influence family planning outcomes. A common example shared was that when impoverished individuals are struggling with food insecurity and housing insecurity, family planning and contraceptive use is not always a priority. To better support client needs beyond family planning and other health care needs, PPNNE is currently working with Vermont's 3 Square Program to establish referrals to and from the Program in an effort to ensure food security among their clients.

Teens. Interviewees indicate need to improve access for teens, particularly teens with health insurance that choose not to use their health insurance for services due to confidentiality concerns. Although this group is a small subset of the population served, PPNNE would like to determine how to best serve this population.

The majority of PPNNE's population served is 16-26 years of age. In their outreach and engagement efforts, PPNNE works to meet teens where they are at, for example, using multiple social media platforms and exploring potential opportunity to use telemedicine to serve teens and mitigate transportation barriers. PPNNE is also starting to work with the school system again and currently has a condom program at their White River Junction site.

Another resource called out to support teens' family planning, reproductive and sexual health needs are SBHCs in Vermont. Interviewees feel they offer an effective mechanism to reach adolescents and provide contraceptive services and/or refer students to other providers to address family planning and other health care needs.

Many interviewees noted concern on maintaining engagement in the health care system as adolescents transition to young adulthood. Continued engagement and use of the health system was indicated as an important facilitator in ensuring continuity of care and preventive care. This is considered important because family planning services are often a primary entry point and use of the health care system for adolescents and young adults, and interviewees indicated that young adults in Vermont experience challenges in obtaining timely access to primary care. Some interviewees felt that integrating well-woman care into family planning and preconception care may be promising strategy to maintain access and engagement in the health system as adolescents transition to adulthood.

Men. PPNNE indicated they are growing the number of male clients served each year, and have made intentional efforts to better reach and serve men. PPNNE's recent rebranding included marketing campaigns inclusive of men (i.e., messaging that in addition to serving women, PPNNE is a place for men to receive high-quality family planning and reproductive health services, too), and the redesign of health centers that are intended to be a comfortable environment for men and women. PPNNE has also tailored services to better reach men and ensure services are inclusive of men's family planning and reproductive health needs (i.e., integrating STI services into patient visits and providing expedited partner treatment).

Interviewees report that men primarily access and use the family planning service delivery system for STI screening. Providers try to segue conversations during visits to talk about contraception, reproductive life planning, and provide some basic primary care (e.g., smoking cessation counseling); transitioning the conversation from STI screening and treatment to reproductive life planning and other health needs can be difficult. Providers feel that until there are more contraceptive options for men, they will continue to serve a much smaller proportion of men than women. Furthermore, PPNNE does not provide vasectomy services, but does offer vasectomy education, counseling, and referral.

In addition to addressing the family planning and reproductive health needs of men, providers would like to expand on the level of education PPNNE provides on intimate partner violence to better reach men. It was suggested that identifying the right community partners may help facilitate this work.

Mental Health/Substance Abuse. Substance abuse was recognized as a growing problem in Vermont and often associated with a transient lifestyle. Interviewees experience that this population can be difficult to reach to address family planning needs because often times substance use or sobriety are deemed a higher priority than family planning and contraception. They would like to determine how to better reach and serve this population. One approach suggested that has been implemented at the St. Albans PPNNE health center is to provide same day access to services and consider how to best offer comprehensive and efficient services within a single visit knowing providers may not see the client again for some time. Furthermore, by coordinating with community-based organizations in select regions, PPNNE has been able to identify how to better serve and meet the needs of this vulnerable population. Regional meetings were coordinated by the Health Department in St. Albans and White River Junction. PPNNE and community-based organization participants found the meetings to be a great help in increasing awareness and building understanding of the services available within communities and the needs of the populations they serve. The Health Department plans to continue coordinating similar meetings in other regions of the state in the future.

LGBTQ. PPNNE interviewees indicated that all providers receive general cultural competency training and training on culturally competent transgender care, lending to an established comfort level with preventive care for transgender among providers. PPNNE's Burlington health center is receiving training to provide trans-care.

Although providers are well-trained to serve the family planning and reproductive health care needs of the LGBTQ population in Vermont, interviewees indicated there is need for more outreach to this population and engagement in the health care system. Additionally, interviewees remarked that while

there are several resources and supports targeting the LGBTQ community within Chittenden County, there are very few in most other parts of the state. This makes it difficult to reach this population as well as provide appropriate supports to this population.

Racial & Ethnic Minorities. As the racial and ethnic minority population in Vermont grows, particularly immigrants and refugees residing in Chittenden County, interviewees are identifying more need to outreach to these populations and to provide culturally sensitive services. For example, providers indicated challenges with addressing family planning needs of some immigrant and refugee patients due to cultural and religious beliefs and attitudes on contraception. The Hispanic/ migrant worker population in Addison County was also called out has a population with unmet health and family planning needs, partly due to cultural barriers and partly due to financial and transportation barriers.

PPNNE interviewees noted efforts to better service racial and ethnic minority populations by way of coordinating with other organizations, including Community Health Centers of Burlington who sees a significant proportion of the immigrant and refugee population in Chittenden County, to establish referrals to PPNNE to serve the family planning and reproductive health needs of this population. PPNNE's Cultural Inclusivity Project has benefited staff in becoming more aware of cultural attitudes, behaviors and beliefs related to family planning. Providers have found their tiered counseling approach works well when broaching contraceptive counseling with the recent immigrant and refugee population. Use of phone interpreters has also facilitated serving the needs of this population.

Incarcerated. Women who are incarcerated in Vermont were noted by PPNNE interviewees as a population of interest with unmet family planning need. The Vermont Department of Corrections reported that approximately 85% (about 850 of 1000 women annually) of their female incarcerated population are 18-44 years of age. PPNNE has initiated conversations with the Department of Corrections to determine if there is a role for PPNNE to support the family planning and reproductive health needs of this population or if there is a better solution to the system.

Considerations

This review of Vermont's family planning system and population needs presents a positive picture overall. Interviewees described a family planning system with high access, high quality, comprehensive services, and a supportive landscape. In addition to the 10 Title X funded health centers, Vermont has a broad network of safety-net providers supporting the health care needs of residents throughout the state. Key health and reproductive health indicators also present a favorable status for Vermonters. Most all Vermonters now have health insurance and Vermont's infant mortality, preterm birth, and low weight birth rates rank lower than national rates. Furthermore, the teen pregnancy rate and fertility rate for Vermont continue to decline and post-partum contraceptive use is high among Vermonters.

Despite these gains, this review indicates remaining challenges for Vermont. The rate of intended pregnancy remains relatively consistent at about 50%, well below the 65% Healthy Vermonters 2020 goal. Furthermore, about half (49%) of mothers whose pregnancies are unintended report using any method of birth control. Alcohol and tobacco use during pregnancy remain consistently high

compared to other states. Several sub-populations of concern were noted as having disparate unmet family planning need due to financial, transportation, and cultural barriers. These sub-populations include adolescents, individuals with mental health and/or substance abuse issues, LGBTQ individuals, and racial and ethnic minorities.

In the context of the gains, strengths, and challenges for Vermont's family planning service delivery system, the following focus areas are called out for consideration and intended to guide future efforts of the Health Department and other family planning programs and stakeholders in Vermont.

I. Assess the financial, service delivery, and access implications due to exclusion of the PPNNE Burlington and Williston health center sites from Title X funding. Interviewees indicated limited understanding as to why the Burlington and Williston sites, which serve the largest number of clients in the state relative to other sites, are not included as Title X sites. There is also uncertainty on whether this exclusion impacts access to services among low-income and other vulnerable populations being served by these sites.

II. Promote awareness, implementation, and adherence to the QFP's evidence-based family planning practice guidelines among providers, family planning programs, and health care organizations in Vermont.
   - Disseminate QFP guidelines and related resources (e.g., job aids, webinars, e-learning courses) to providers, programs and organizations. Refer to OPA's National Family Planning Training Centers for existing resources. Explore dissemination mechanisms such as developing a resource hub for providers to access information, announcements, and tools.
   - Identify, coordinate, and support opportunities for provider education and training on QFP guidelines, with a focus on contraceptive effectiveness counseling and informed choice.

III. Explore implementing a quality improvement initiative within hospital systems and/or health care organizations (e.g., FQHCs) throughout the state to promote access to high-quality family planning services with emphasis on the provider's role in family planning and contraceptive counseling. Providers should offer contraceptive services for women and men who want to prevent pregnancy and space births, including contraceptive counseling services. For individuals who might want to get pregnant in the future and prefer a reversible method of contraception, providers should use a tiered approach to presenting a broad range of contraceptive methods, presenting the most effective methods before less effective methods.[53]
   - Explore the use of family planning quality measures among health care organizations to monitor on an ongoing basis (e.g., percentage of patients using moderately or highly effective contraceptive methods; or percentage of patients using LARC methods). Refer to

[53] Gavin L, Moskosky S, Carter M, et. al. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. MMMR 2014; 63(No. 4).

the QFP and OPA National Family Planning Training Centers for guidance on performance measures.

IV. **Continue to explore how to increase access to LARC in a broader way (e.g., beyond PPNNE's heath centers); support innovations and solutions to promote access and awareness of LARC.**
- Work with Medicaid to establish reimbursement for post-partum provision of IUD
- Coordinate with ACOs to include LARC use as a payment measure
- Assess access and provision of LARC via other safety net providers such as FQHCs and RHCs
- Explore use of quality improvement initiatives with safety net providers (e.g., FQHCs, RHCs) and primary care providers to promote a broad range of contraceptive method availability, and guideline-based contraceptive counseling and education
- Establish collaborative agreements and referrals systems with PPNNE and other safety net providers well-equipped to provide LARC (e.g., Community Health Centers of Burlington)

V. **Facilitate linkages between primary care providers and Title X health centers in Vermont.** Vermont's network of Title X health centers provides access to comprehensive guideline-based family planning services throughout the state. Coordinate with primary care providers and practices, such as community health centers, to better understand: (1) their capacity for providing guideline-based contraceptive services and other family planning services; (2) existing referral systems; and (3) opportunities to support or strengthen referral systems with Title X health centers to ensure access to comprehensive high-quality family planning services and continuity of care.

VI. **Increase provider and consumer knowledge of covered family planning and related preventive health services.** The Affordable Care Act has expanded health payer coverage of contraception and a wide range of preventive services, including well-woman visits (Pap tests, cancer screenings, etc.). To promote high utilization of expanded health care benefits, disseminate information on covered family planning and related preventive health services to providers and consumers throughout Vermont. Explore dissemination and repackaging of existing information and education resources as well as developing resources specific to Vermont's health payer member benefits.

VII. **Explore potential opportunities to address family planning, reproductive, and sexual health needs of adolescents within SBHCs in Vermont.**
- Establish understanding of existing SBHCs in Vermont, including location, model of care, scope of services, and community linkages
- Coordinate with SBHCs to identify prominent family planning, reproductive health, and sexual health needs within communities and related services that could be feasibly integrated into SBHCs scope of services
- Assess other state models of SBHCs and scope of family planning services offered

VIII. Explore opportunities for clinical-community linkages between Vermont Title X health centers and community based organizations to establish family planning—human service referral networks.

- Continue Health Department coordination of regional meetings convening PPNNE Title X sites and community programs and organizations to build awareness and understanding of community specific needs and available resources.
- Establish referral networks of social support services within Title X sites; PPNNE recently added centralized care coordinator may be an opportunity to facilitate this effort
- Identify and reach out to programs or organizations currently working with high priority populations to increase awareness of Title X site family planning services and opportunities for outreach and engagement of priority populations (e.g., DVHA MOMS Program, Howard Center, Pride Center, Vermont Refugee Resettlement Program)

Appendix I: Key Informant Interview Participants & Guides

The following table includes the list of organizations, programs, and groups represented in the series of interviews and discussion groups conducted for the 2015 Title X needs assessment interviews. Examples of the guides used to facilitate discussion during interviews follow.

Title X Needs Assessment Key Informant Groups and Organizations	
1	Community Health Centers of Burlington
2	Department of Vermont Health Access, Integrated Family Services
3	Department of Vermont Health Access, Medicaid Obstetrical and Maternal Support Program
4	Department of Vermont Health Access, Policy
5	Parent Child Centers
6	Planned Parenthood of Northern New England
7	University of Vermont
8	UVM Pediatric Primary Care
9	Vermont Center for Health and Learning
10	Vermont Department of Health School Liaisons
11	Vermont Department of Health, Health Promotion Disease Prevention
12	Vermont Department of Health, Maternal and Child Health
13	Vermont Family Network
14	Vermont Federation of Families for Children's Mental Health
15	Vermont PREP Grantees
16	Vermont Primary Care and Public Health Integration Group

Title V Strengths and Needs Assessment
Key Informant Interview Guide

For the 2015 Title V strengths and needs assessment states must identify 7 among the 15 National Performance Measures they will prioritize to improve the health and wellbeing of Vermont's women, mothers, children and families.

Title V of the Social Security Act reflects our nation's commitment to improving the health and well-being of mothers, children, and their families, and is operationalized through a block grant. Every five years, as a part of the federal Title V Block Grant, states are required to complete a comprehensive assessment of the needs, desired outcomes, and system capacity for the maternal and child health population, including children and youth with special health care needs. The results of this assessment will be used to establish the priorities that will guide our Title V program for the next five years (2015-2020).

Background: This is an exciting time in the field of Maternal and Child Health, as the Title V MCH Block Grant is currently undergoing a transformation. One of the primary goals of this transformation is to demonstrate the vital leadership role that state Title V programs play in assuring and advancing public health systems that address MCH population health needs. To achieve this goal, the federal Maternal and Child Health Bureau has defined a core set of national health priority areas that Title V programs across the country will work on to collectively "move the needle." Fifteen national health priority areas have been identified (see Table 1), from which states must select seven to ten to address through their Title V program along with any state specific priority areas. Collectively, these priority areas represent six MCH population domains: 1) Women/Maternal Health; 2) Perinatal/Infant Health; 3) Child Health; 4) Adolescent Health; 5) CYSHCN; and 6) Cross-cutting or Life course. You have been identified as someone with expertise in the ______________________population domain(s). Throughout the interview, I will be referring to this domain and the corresponding national priority areas (see Tale 1). VDH is also currently conducting their 2015 Title X Needs Assessment. Vermont's Title X program provides high quality clinical family planning (e.g., a broad range of FDA-approved contraceptive methods and related counseling) and related preventive health services, including breast and cervical cancer screening; pregnancy testing and counseling; screening and treatment for sexually transmitted infections (STIs); HIV testing; and other patient education and referrals to women and men in Vermont who would otherwise not have access, with a special focus on low-income and rural populations. You have been identified by VDH as well suited to speak to 1) the _____________ domain to inform the VDH'S 2015 Title V Needs Assessment, and 2) the family planning needs ands and services in Vermont for VDH's 2015 Title X Needs Assessment.

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1. Let's begin by setting the context for the interview. Can you briefly describe your organization and its role in addressing the needs of Vermont's women, mothers, children and families?
    a. Describe specific programs
    b. Reach/ Population focus
    c. Partnerships across the state

2. Now let's turn to thinking about the quality of the system of care for Vermont's women, mothers, children and families. Components of a quality system include *accessible*, *equitable*, *timely*, *coordinated*, *client-centered*, and *culturally competent* care.
    a. What components of quality are well-addressed within Vermont's current system of services and supports for women, mothers, children and families?
    b. What components of quality could be better addressed within Vermont's current system of services and supports for women, mothers, children and families?

3. Thinking about [population domain] and the corresponding national priority areas identified by the federal Bureau of Maternal of Child Health....

    a. What have been some gains in this area for Vermont?
    b. What have been the challenges?
    c. What do you see as key strategies for addressing this issue?
    d. What would be some challenges encountered?
    e. What are the leverage points/opportunities that exist to address this issue (e.g., existing initiatives, coalitions, etc.)?

4. The sixth population domain is Cross-cutting or Life Course and refers to public health issues that impact multiple MCH population groups such as smoking or oral health. What do you see as significant cross-cutting issues for Vermont's MCH populations? Why?

    a. Cross-cutting or Life Course can also include social determinants of health—how where we live, learn, work and play impacts our overall health and well-being. How do you see social determinants of health playing into the health and well-being of Vermont's women, mothers, children and families?
        i. Which of those that you listed has the greatest impact for [population domain]?

<u>Title X</u>

The U.S. Department of Health and Human Services' Office of Population Affairs (OPA) oversees the Title X program. OPA funds a network of family planning centers which serve about five million clients a year. Services are provided through state, county, and local health departments; community health centers; Planned Parenthood centers; and hospital-based, school-based, faith-based, other private nonprofits. Title X family planning centers provide high quality and cost-effective family planning and related preventive health services for low-income women and men including a broad range of FDA-approved contraceptive methods and related counseling; as well as breast and cervical cancer screening; pregnancy testing and counseling; screening and treatment for sexually transmitted infections (STIs); HIV testing; and other patient education and referrals. Family planning centers play a critical role in ensuring access to voluntary family planning information and services for their clients based on their ability to pay. Every three years states receiving Title X funds are required to conduct a family planning needs assessment. Title X and Title V needs assessment processes overlap for the 2015 cycle. We understand that your work interfaces with the family planning system. We would like to ask you a few questions specific to family planning.

5. Describe your involvement in the family planning system in Vermont?

6. Describe the populations most in need of family planning services in Vermont?

    a. What is Vermont currently doing on outreach and access to best meet the needs of these populations?
    b. Is the system effectively reaching and engaging vulnerable populations?
        i. What are the barriers or challenges to doing so?
        ii. What more could be done to engage vulnerable populations?
    c. What are their most pressing family planning needs?
    d. What more could providers and/or the system be doing?

Recommendations/Closing Observations

7. As we come to the close of our interview, what are the top recommendations you have for ensuring an accessible high-quality system of support and services for Vermont's women, mothers, children and families?

8. Are there any closing observations or thoughts you would like to share regarding ________________ [population domain] and how Vermont can strive to ensure the overall health and well-being of_________________________[population domain]?

Table 1: National Priority Areas by Population Domain

MCH Population Domain	National Priority Area
Women/Maternal Health	Well Woman Care Low Risk Cesarean Deliveries
Perinatal/Infant Health	Perinatal Regionalization Breastfeeding Safe Sleep
Child Health	Developmental Screening Injury Prevention Physical Activity
Adolescent Health	Injury Prevention Physical Activity Bullying Adolescent Well Visit
Children and Youth with Special Health Care Needs	Medical Home Transition
Cross-cutting/Life course	Oral Health Smoking Adequate Insurance Coverage

Vermont Title X Needs Assessment
Key Informant Interview Guide

Background: Title X of the Public Health Service Act is designed to ensure access to comprehensive reproductive health care, with an emphasis on services to lower income women and men. The U.S. Department of Health and Human Services' Office of Population Affairs (OPA) oversees the Title X program. OPA funds a network of family planning centers which serve about five million clients a year. Services are provided through state, county, and local health departments; community health centers; Planned Parenthood centers; and hospital-based, school-based, faith-based, other private nonprofits. In Vermont, Title X services are provided by Planned Parenthood of Northern New England.

The overarching goal of Vermont's Title X program is to provide high quality clinical family planning (e.g., a broad range of FDA-approved contraceptive methods and related counseling) and related preventive health services, including breast and cervical cancer screening; pregnancy testing and counseling; screening and treatment for sexually transmitted infections (STIs); HIV testing; and other patient education and referrals to women and men in Vermont who would otherwise not have access, with a special focus on low-income and rural populations. Specifically, Vermont's Title X program seeks to:

- Reduce unintended pregnancies in Vermont
- Improve access to a broad range of effective contraceptive methods
- Provide access to emergency contraceptive services
- Reduce sexually transmitted diseases
- Promote healthy relationships, healthy sexual behaviors and strengthen community capacity to promote positive reproductive health

Thank you for taking the time to participate in Vermont's 2015 Title X needs assessment process by way of this interview. The information collected from key informants will be used by the Vermont Department of Health's Division of Maternal and Child Health to inform 1) their upcoming application to OPA for continued Title X funding in Vermont, and 2) planning and priorities of their future Title X, family planning, and reproductive-health related work.

---

1. Let's begin by setting the context for the interview. Can you briefly describe your organization and its involvement in the family planning system in Vermont?
    a. Describe specific programs
    b. Reach/ population focus

2. Thinking about Title X and the family planning service delivery system in Vermont, what are the strengths of Vermont's Title X service delivery system and/or existing family planning services?
    a. What have been some of the gains for Vermont in recent years?
    b. To what do you attribute these gains?
    c. What partners are important to expanding or enhancing the Title X service delivery system?

   d. Which of these partners do you collaborate/partner with, and how, to meet family planning needs in the state?

3. Similarly, what are some of the barriers or challenges of Vermont's Title X service delivery system and/or existing family planning services?
   a. What are potential strategies to address barriers or challenges of the system?

Access & Quality

4. Describe the populations most in need of family planning services in Vermont?
   a. What are we currently doing on outreach and access to best meet the need(s) of these populations?
   b. What more could providers and/or the system be doing?

5. Is the system adequately reaching the needs of vulnerable populations (e.g., teens, LGBT, racial and ethnic minorities, recent immigrants and refugees)?
   a. Is the system effectively reaching and engaging vulnerable populations?
      i. What are the barriers or challenges to doing so?
      ii. What more could Title X/PPNNE centers and other providers do to engage vulnerable populations?
   b. What are their most pressing family planning needs?

6. Is the system effectively reaching and engaging men?
   a. What are the barriers or challenges to doing so?
   b. What types of services are most commonly delivered to the men served in your program/organization?
   c. What more could Title X/PPNNE centers do to engage men?

7. Now let's turn to thinking about the quality of the family planning service delivery system in Vermont. Components of a quality system include *accessible*, *equitable*, *timely*, *coordinated*, *client-centered*, and *culturally competent* care.
   a. What components of quality are well-addressed within Vermont's current system of family planning and reproductive health care?
   b. What components of quality could be better addressed within Vermont's current system of family planning and reproductive health care?

Long-Acting Reversible Contraceptives (LARCs)

8. To what extent do you feel family planning patients have access to a broad range of contraceptive options, including long acting reversible contraceptives (LARCs)?
   a. What are the primary barriers to promoting use of LARCs to prevent unintended pregnancy?
      i. Provider training and skills to counsel and provide LARCS

ii. Adolescents' knowledge, attitudes, beliefs, and use of LARCs

<u>Preconception Health & Related Preventive Health Services</u>

9. Promoting preconception health and reproductive health planning are important components of family planning, as they influence birth outcomes and men and women's health in general. How does Vermont's family planning service delivery system fair in regard to providing recommended preconception health services (i.e., per USPSTF recommendations)?
    a. What are some of the challenges or barriers to doing so?

10. The family planning service delivery system is often a point of access into the health care system for many women and men, and therefore presents an important opportunity to provide or refer for other related preventive health care services (e.g., cervical cancer screening, breast cancer screening). Similar to the previous question, how does Vermont's family planning service delivery system fair in regard to providing or referring clients for other preventive health services?
    a. What are some of the challenges or barriers to doing so?

11. To wrap up our discussion, what are the top recommendations you have for ensuring an accessible high-quality system of family planning and reproductive health in Vermont?

From:	Clark, Charity
To:	Diamond, Joshua
Cc:	Spottswood, Eleanor
Subject:	Fwd: Title X stats and clinic locations
Date:	Wednesday, July 11, 2018 7:16:46 PM
Attachments:	cyf_TX Needs Assessment 2015.pdf ATT00001.htm

Perhaps we should have the press conference at one of these Title X health centers? None are in Burlington, but one is in St. Albans and another in Barre.

Charity

Sent from my iPhone

Begin forwarded message:

> **From:** "Spottswood, Eleanor" <Eleanor.Spottswood@vermont.gov>
> **Date:** July 11, 2018 at 5:57:42 PM EDT
> **To:** "Clark, Charity" <Charity.Clark@vermont.gov>
> **Subject: Title X stats and clinic locations**
>
> Charity-
>
> For future reference: this is the most recent document with Vermont-specific Title X data in it. A (rough) map of all the Title X clinic locations is on pdf page 9.
>
> Thanks for your help today!
>
> Ella
>
> Eleanor L.P. Spottswood
> Assistant Attorney General
> Vermont Attorney General's Office
> 109 State Street
> Montpelier, Vermont 05609
> 802-828-3178
> eleanor.spottswood@vermont.gov

Vermont Title X
Family Planning Needs Assessment

Prepared by JSI Research & Training Institute, Inc. for the
Vermont Department of Health

October 2015

VERMONT
DEPARTMENT OF HEALTH

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Executive Summary

Title X is the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. For more than 45 years, Title X-funded health centers have provided high-quality cost-effective family planning and related preventive health services to low-income, under-insured and uninsured women and men who may otherwise lack access to health care. These health centers play a critical role in ensuring access to voluntary family planning information and services for their clients based on their ability to pay.

The 2015 Vermont Title X assessment process helps to ensure that the state's safety net for sexual and reproductive health services continues to meet the needs of women 15-44 years of age, particularly the most vulnerable. The findings and considerations from the Title X Needs Assessment will guide the Vermont Department of Health (Health Department) and other stakeholders in the planning, programming, and provision of services to ensure a high quality family planning service delivery system that supports Vermont's most vulnerable populations. This report provides a demographic description of Vermont as it relates to family planning, a description of Vermont's Title X family planning system, and a description of Vermont's family planning and reproductive health services and population needs. A summary of the findings and considerations follow.

Vermont Population

- Vermont is one of the most rural states in the U.S., and one of the smallest, with about 626,630 residents in 2013.
- Over 60% of Vermonters live in rural areas of the state. By a large majority, most Vermonters are white (95%), non-Hispanic (98%).
- In 2013, 9% of the Vermont population was under 100% of the federal poverty level (FPL).

Insurance Status

- In 2014, 21% or 132,829 of Vermonters were covered by Medicaid.
- In 2014, about 3.7% or 23,000 Vermonters were uninsured.

Unintended Pregnancy & Teen Pregnancy

- About half of pregnancies among Vermonters are unintended.
- In 2013, the pregnancy rate in Vermont was 61.2 pregnancies per 1,000 women age 15 to 44. The teen pregnancy rate was 21.9 pregnancies per 1,000 women age 15 to 19 years.

Births & Infant Mortality

- In 2013, Vermont had a birth rate of 51.2 births per 1,000 women 15-44 years of age. The teen birth rate was 14.5 births per 1,000 women 15-19 years of age.
- In 2013, Vermont had a preterm birth rate of 8.1%, a low birthweight rate of 7.0%, and an infant mortality rate of 5.0%.

Sexually Transmitted Infections & HIV

- Vermont ranks 44th in rates of syphilis and 46th in rates of both chlamydia and gonorrhea among the 50 states.
- In 2012, the rate of primary and secondary syphilis was 1.0 per 100,000 Vermonters, the rate of chlamydia infections was 275.2 per 100,000 and the rate of gonorrhea was 408.1 per 100,000.
- In 2011, 12 adults and adolescents were diagnosed with HIV in Vermont. Vermont ranked 50th among the 50 states in the number of HIV diagnoses.

Title X in Vermont

The Health Department, the Title X grantee for the state of Vermont, contracts with Planned Parenthood of Northern New England (PPNNE) to provide Title X supported family planning services throughout the state, with a special focus on serving low-income and rural populations.

- In 2013, Title X family planning services helped women in Vermont avoid 2,000 unintended pregnancies, 1000 unplanned births, and 700 abortions, including 400 pregnancies to teens, 200 births to teens, and 100 abortions to teens.
- In 2014, PPNNE's Title X health centers served 7,796 women and 923 men, for a total of 8,719 residents of Vermont.
    - 47% had incomes at or below 100% of the FPL
    - 77% had incomes at or below 250% of the FPL
    - 24% were uninsured
    - 21% were teens under the age of 20, and
    - 11% were men.

- In 2014, 7714 female clients not pregnant or seeking pregnancy were using the following contraceptive methods:
    - 53% Moderately effective hormonal method – pill, patch, ring, Depo
    - 16% Long-acting reversible contraception (LARC) – IUD or implant
    - 3% Permanent sterilization

- In 2014, of the 776 male clients not seeking pregnancy, 65% were using the male condom, 1% vasectomy, 1% withdrawal, and 2% relied on a female method for contraception.

Strengths & Challenges of Vermont's Family Planning Service Delivery System

- Vermont's Title X-funded health centers provide comprehensive, standardized, high-quality, timely and accessible family planning and reproductive health care throughout the state.
- Vermont's expanded Medicaid program and the Access Plan bolster access to family planning services in the state. Vermont has a relatively low proportion of uninsured individuals.
- Vermont has done good work in HIV and sexuality education within schools using research and evidence-based curricula. School Liaisons and school nurses work to coordinate with local parent child centers and providers to support student reproductive and sexual health needs.
- Energy and efforts to improve access to LARC methods in Vermont, specifically within PPNNE's network of health centers, have been successful in promoting use. Remaining challenges exist, including attitudes and beliefs on use of LARC and reimbursement barriers for providing LARC.

- Disparities in unmet family planning need and health outcomes exist in vulnerable population groups throughout the state, including individuals with low income; teens; individuals with mental health and/or substance abuse issues; lesbian, gay, bisexual, transgender and queer population; racial and ethnic minorities; and incarcerated women.

Summary & Considerations

This review of Vermont's family planning system and population needs presents a positive picture overall. The family planning system is thought to have good access with high quality, comprehensive services, and a supportive landscape. In addition to the 10 Title X funded health centers, Vermont has a broad network of safety-net providers supporting the health care needs of residents throughout the state. Key health and reproductive health indicators also present a favorable status for Vermonters. Most all Vermonters now have health insurance and Vermont's infant mortality, preterm birth, and low weight birth rates rank lower than national rates. Furthermore, the teen pregnancy rate and overall fertility rate for Vermont continue to decline while post-partum contraceptive use is high among Vermonters.

Despite these gains, this review indicates remaining challenges for Vermont. The rate of intended pregnancy remains relatively consistent at about 50%, well below the 65% Healthy Vermonters 2020 goal. Furthermore, fewer than half (49%) of mothers whose pregnancies were unintended reported using any method of birth control. Alcohol and tobacco use during pregnancy remain consistently high compared to other states. Several sub-populations of concern were noted as having disparate unmet family planning need due to financial, transportation, and cultural barriers.

In the context of the gains, strengths, and challenges for Vermont's family planning service delivery system, the following focus areas are called out for consideration and intended to guide future efforts of the Health Department and other family planning programs and stakeholders in Vermont.

I. Assess the financial, service delivery, and access implications due to exclusion of the PPNNE Burlington and Williston health center sites from Title X funding.

II. Promote awareness, implementation, and adherence to evidence-based family planning practice guidelines among providers, family planning programs, and health care organizations in Vermont.

III. Explore implementing a quality improvement initiative within hospital systems and/or health care organizations (e.g., FQHCs) throughout the state to promote access to high-quality family planning services with emphasis on the provider's role in family planning and contraceptive counseling.

IV. Continue to explore how to increase access to LARC in a broader way (e.g., beyond PPNNE's heath centers); support innovations and solutions to promote access and awareness of LARC.

V. Facilitate linkages between primary care providers and Title X health centers in Vermont.

VI. Increase provider and consumer knowledge of covered family planning and related preventive health services.

VII. Explore potential opportunities to address family planning, reproductive and sexual health needs of adolescents within school-based health centers in Vermont.

VIII. Explore opportunities for clinical-community linkages between Vermont Title X health centers and community based organizations to establish family planning—human service referral networks.

The considerations are further described on page 25 of the full report.

Introduction

The Title X family planning program is the nation's only dedicated source of federal funding for comprehensive family planning and related preventive health services. The United States Department of Health and Human Services' Office of Population Affairs (OPA) oversees the Title X program and funds a network of family planning centers across the country that serve about five million low-income women and men each year. Services are provided through state, county, and local health departments; community health centers; Planned Parenthood centers; and hospital-based, school-based, faith-based, and other private nonprofits. In addition, Title X is the only federal program that funds critical infrastructure needs not paid for under Medicaid and private insurance, such as staff salaries, patient education, and community education about family planning and sexual health issues. Title X is also used to subsidize health center rent, utilities, and health information technology.

For more than 45 years, the Title X program has supported clinics to provide family planning services and other preventive health care to low-income, under-insured and uninsured individuals who may otherwise lack access to health care. Title X family planning centers play a critical role in ensuring access to voluntary family planning information and services. They provide high quality, culturally-sensitive, and cost-effective family planning and related preventive health services for low-income women and men including a broad range of FDA-approved contraceptive methods and related counseling; as well as breast and cervical cancer screening; pregnancy testing and counseling; screening and treatment for sexually transmitted infections (STIs); HIV testing; and other patient education and referrals.

Title X in a Changing Health Care Environment. Title X, like many large and historical grant programs, was significantly and positively impacted by the passage of the Patient Protection and Affordable Care Act (ACA). ACA put in place comprehensive health insurance reform expanding access to sexual and reproductive health services thus decreasing the likelihood that coverage is the predominant access issue. The law makes preventive care—including family planning and related care—more accessible and affordable for many Americans. With the implementation of the ACA and expansion of Medicaid, more Americans, including Vermonters, will have health insurance, including coverage of a full range of family planning and related preventive services without out-of-pocket costs. As the health care systems in the United States (U.S.) and Vermont reform, Title X-funded health centers will continue to be important safety-net providers, and will continue to serve: individuals who don't qualify for health insurance, underinsured individuals, insured and uninsured individuals where confidentiality cannot be ensured (e.g., adolescents), and individuals who want to continue receiving care at a family planning site.

Additionally, as our health system evolves to expand access to care, initiatives to improve and ensure quality of care are also being implemented. In 2014, the OPA and Centers for Disease Control and Prevention (CDC) released new recommendations called *Providing Quality Family Planning Services*

(QFP).[1] The QFP provides clear evidence-based clinical practice guidelines intended to improve the quality of family planning services and thereby improve reproductive health outcomes. The QFP recommendations: (1) define a core set of family planning services for women and men, including contraceptive services, pregnancy testing and counseling, helping clients achieve pregnancy, basic infertility services, preconception health services, and sexually transmitted disease services; (2) describe how to provide contraceptive and other clinical services, serve adolescents, and conduct quality improvement; and (3) encourage the use of the family planning visit to provide selected preventive health services for women, in accordance with the national recommendations for guideline-based care for women. The QFP recommendations supplement the *Title X Program Requirements*[2] and are intended for all providers of family planning services, in addition to Title X-funded programs. Implementing the QFP clinical guidelines in addition to Title X Program Requirements will help Title X-funded programs improve family planning service delivery and provide the services and supports couples need to achieve their desired number and spacing of children.

Title X-funded health centers serve a fundamental role in providing health care to Vermonters. Compared to other health providers in the state, Title X centers in Vermont are ahead of the curve in providing comprehensive high-quality, guideline-based, culturally competent family planning and reproductive health care. However, there is still room for improvement. The 2015 Vermont Title X assessment process helps to ensure that the state's safety net for sexual and reproductive health services continues to meet the needs of women 15-44 years of age, particularly the most vulnerable. The findings and considerations from the Title X Needs Assessment will guide the Vermont Department of Health (Health Department), policy makers, healthcare providers, health and human service organizations, schools and communities in Vermont in their planning, programming, and provision of services to ensure a high quality family planning service delivery system that supports Vermont's most vulnerable populations. This report provides a demographic description of Vermont as it relates to family planning, a description of Vermont's Title X family planning system and services, and a description of Vermont's family planning and reproductive health services and population needs.

Needs Assessment Process

Vermont's approach to the 2015 Title X Needs Assessment was designed to examine both strengths and needs of the state's family planning service delivery system, and the family planning and reproductive health needs of Vermonters. Additionally, the QFP,[3] which provides recommendations for delivering quality family planning services, was used as a framework to inform the needs assessment and its findings and considerations.

[1] Gavin L, Moskosky S, Carter M, et. al. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. MMMR 2014; 63(No. 4).
[2] Office of Population Affairs. Program Requirements for Title X Funded Family Planning Projects. April 2014.
[3] Gavin L, Moskosky S, Carter M, et. al. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. MMMR 2014; 63(No. 4).

Overall direction for Vermont's 2015 Title X Needs Assessment was provided by the Health Department Director of Preventive Reproductive Health, including input on the assessment process, identification of stakeholders to participate in key informant interviews and group discussion, review of data as well as the development of the final report and considerations. The 2015 Title X Needs Assessment consisted of two primary information gathering processes: (1) review and analysis of public health surveillance data, including secondary quantitative data (e.g., Family Planning Annual Report) and (2) qualitative data collected through a series of key informant interviews and group discussions with Vermont's family planning and maternal and child health (MCH) stakeholders. Stakeholders represented Planned Parenthood of Northern New England (PPNNE), MCH Coordinators, Parent Child Centers, public health professionals, School Liaisons, medical providers, human service providers (e.g. early childhood) and state program administrators. Over 40 stakeholders were identified who then participated in either individual or group discussions with a total of 23 conducted. Interviews and group discussions explored family planning and related preventive health service needs, including needs of vulnerable populations; family planning systems and supports, including quality; strengths and challenges for family planning services; and, opportunities for improvements and/or assets to be leveraged. A complete list of interviewees and interview guides are available in Appendix I.

Vermont's Family Planning Safety-Net

Title X. Vermont has been funded by the Title X program since its inception, with the overarching goal to *provide high quality clinical family planning and related preventive health services, education, and counseling to Vermonters who would otherwise not have access, with a special focus on low-income and rural populations*. The Vermont Department of Health, the Title X grantee for the state of Vermont, contracts with Planned Parenthood of Northern New England (PPNNE) to provide Title X supported family planning services throughout the state. Ten of PPNNE's 12 Vermont health centers are supported with Title X funds; Title X sites are located in Barre, Bennington, Brattleboro, Hyde Park, Rutland, Middlebury, Newport, St. Albans, St. Johnsbury

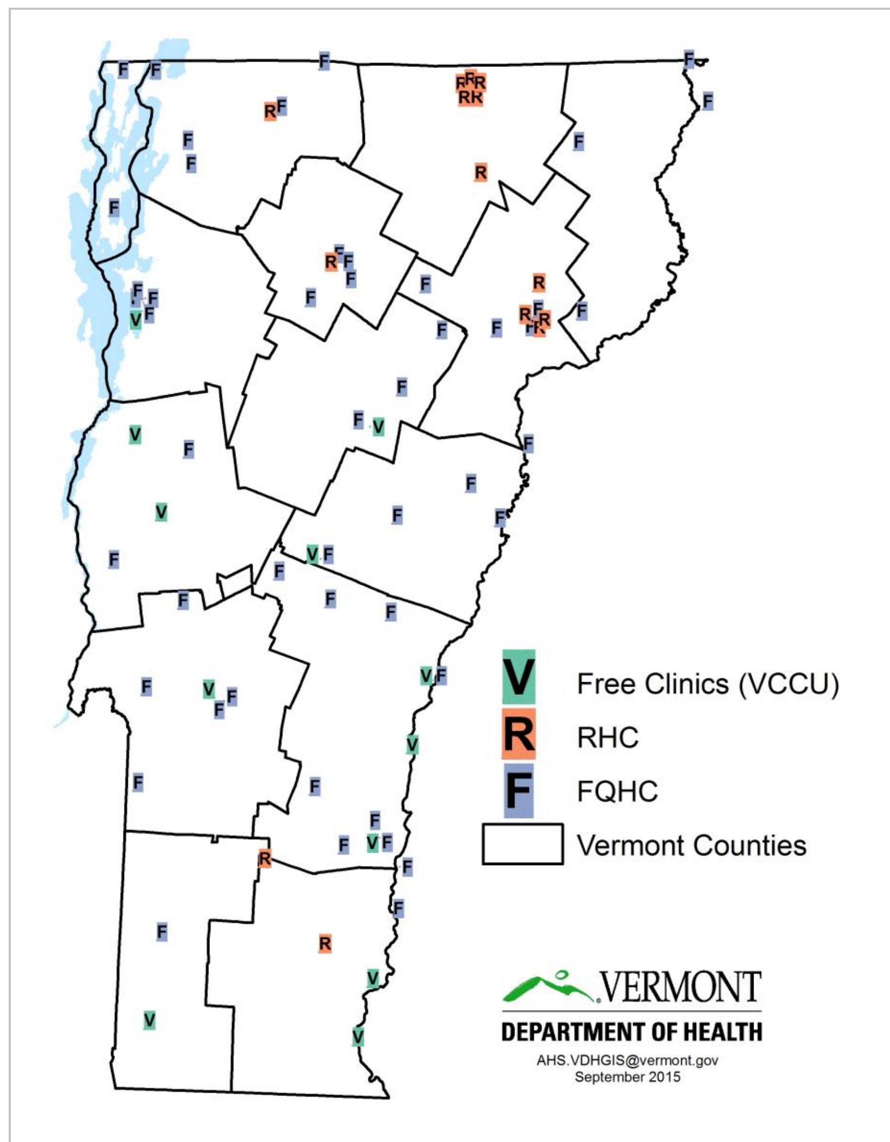
Figure 1. PPNNE Vermont Health Center Sites, 2015

and White River Junction[4] (Figure 1). At present, the PPNNE health centers in Burlington and Williston are not Title X sites. This network of health centers serves as a foundation for providing sexual and reproductive health, and related preventive health services to Vermont's low-income and vulnerable populations.

The state's Title X-funded health centers provide comprehensive family planning and related preventive health services, including contraceptive services; pregnancy testing and counseling; screening, testing, and treatment for sexually transmitted infections; rapid HIV testing; screening for breast, cervical, colorectal, and testicular cancer; preconception education and prenatal referral; basic fertility services; well woman visits; screening for high blood pressure, diabetes and obesity; and referrals for other health and social services. All services provided are based on and adhere to national clinical guidelines and recommendations.

Other Safety-Net Providers. In addition to Vermont's network of Title X health centers, several other organizations and clinics make up Vermont's safety net, including Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), free clinics, and Vermont's hospital system. Across the country FQHCs and RHCs play a critical role in many communities in ensuring access to care for the uninsured and underinsured. FQHCs and RHCs provide primary care in areas designated by the federal government as underserved; and benefit from an enhanced reimbursement for Medicaid and Medicare services.

There are 12 FQHCs and 12 RHCs located throughout Vermont (Figure 2). FQHCs provide comprehensive



[4]The White River Junction health center site is currently funded by New Hampshire's Title X funding.

Figure 2. Vermont healthcare safety-net sites: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Vermont free clinics. 2015

primary care services across the life span. They are organized as a network of clinics or satellites with a central administration. In Vermont, FQHCs have about 50 primary care sites located in 13 of the state's 14 counties.[5] RHCs are only developed in rural areas and specialize in primary care (pediatrics, internal medicine, family practice, obstetrics).

Vermont's network of free clinics adds further strength to the state's safety net system. The Vermont Coalition of Clinics for the Uninsured (VCCU) is the association of 10 organizations serving the needs of Vermonters without adequate medical and dental insurance and without the means to pay for their health care. Six of these clinics provide onsite medical care by volunteer clinician teams, three offer dental care, and four refer patients to available local clinicians. At each clinic, adult patients are screened for eligibility for various public assistance programs including hospital affordable care programs and Medicaid extension programs.[6]

Vermont's hospitals are also an important safety-net provider of the family planning service delivery system. In particular are Vermont's eight critical access hospitals located in rural communities throughout the state and serve as the first line of defense in emergency situations. The critical access hospitals are all non-profit and required by Vermont to provide care to anyone who walks in the door without regard to insurance status or ability to pay.

Other Vermont Resources to Support Family Planning Needs

Other assets in the state intended to support the reproductive and sexual health needs of Vermonters include: "The Access Plan", the Vermont Sexual Health & Education Program (V-SHEP), the Personal Responsibility Education Program or PREP, school-based health centers, and the Department for Vermont Health Access Medicaid Obstetrical and Maternal Support (MOMS) Program.

Nationally and in Vermont, innovative Medicaid-related initiatives are being implemented to increase access to family planning services. In 2012, the Health Department initiated a program with PPNNE branded "The Access Plan". Vermont has not yet implemented the State eligibility option for family planning services and The Access Plan offers the same statewide scope of services for the same population, using funding through Vermont's 1115 Medicaid waiver. This program provides access to free, confidential and convenient family planning services and supplies to men and women in Vermont who have incomes below 200% FPL and are underinsured or uninsured. Eligible individuals can enroll in The Access Plan at any PPNNE health center in Vermont. Covered services include birth control, annual exams, STI testing and treatment, patient education and counseling, and others.

In 2013 Vermont received a CDC grant award called "Promoting Adolescent Health Through School-Based HIV/STD Prevention" to create the Vermont Sexual Health & Education Program (V-SHEP). From 2013-2018 the Agency of Education is working with 15 supervisory unions and school districts throughout Vermont to assist in improving sexual health and education for middle and high school students. There are three main components to this work: providing comprehensive sexual health

[5] Vermont State Office of Rural Health and Primary Care, 2015

[6] Vermont State Office of Rural Health and Primary Care, 2015

education, working with school nurses to ensure all students have a medical home and receive guideline-based preventive pediatric health care, and providing a learning environment in which all students can expect to feel safe and supported. The Agency of Education is partnering with several local and national partners to implement this work including Outright Vermont in Burlington, The Center for Health and Learning in Brattleboro, and Answer, which is a national sexual education organization.

In 2011, the Health Department was awarded a Personal Responsibility Education Program (PREP) grant to support comprehensive education on sexual health, abstinence, and contraception for the prevention of pregnancy and sexually transmitted infections (STIs). The program targets youth between ages 10-19 who are homeless, in foster care, live in rural areas or in geographic areas with high teen birth rates, or come from racial or ethnic minority groups. The program also supports pregnant and parenting youth under 21 years of age. The Health Department is currently funding six community-based organizations throughout the state to implement PREP; PREP is offered at 13 sites across the state and will serve approximately 440 youth in the 2015 grant year.

School-based health centers (SBHC) have become an important method of health care delivery for youth throughout the country. They provide a variety of health care services to youth in a convenient and accessible environment. Although SBHC models vary, they are typically operated as a partnership between the school and a community health organization, such as a community health center. The services provided by SBHCs vary based on community needs and resources as determined through collaborations between the community, the school district and the health care providers. Currently, there are about five SBHCs in Vermont, including in Burlington High School and in St. Albans. The structure of SBHCs in Vermont varies depending on need and they are intended to supplement rather than replace the medical home. They assure the provision of key physical and mental health services as well as preventive health services.

The MOMS Program is administered through the Vermont Chronic Care Initiative (VCCI) at the Department of Vermont Health Access. The goal of this program is to improve pregnancy outcomes for Medicaid covered pregnant women considered high risk due to a mental health condition, substance use, and/or having had a previous pre-term delivery prior to 32 weeks gestation. Them MOMS Program provides enhanced prenatal care that includes a comprehensive psychosocial assessment, care coordination, an individualized maternity care plan, and referral to other social support services and resources that may result in improved pregnancy outcomes.

Vermont Geographic, Demographic & Socioeconomic Overview

Geography. Vermont is one of the most rural states in the U.S., and one of the smallest, with a population estimate of 626,630 in 2013.[7] Vermont has only one true urban area (i.e. metropolitan statistical area) comprised of Chittenden, Franklin, and Grand Isle counties. Over 60% of Vermont's population resides in rural areas.[8]

Demographics. In 2013, Vermont's population distribution by age was estimated as follows:[9]

- 19.6% children 0-17 years of age
- 33.8% adults 18-44 years of age
- 30.2% adults 45-64 years of age
- 16.4% 65 years of age and older

About 51% of Vermont's population is female.[10]

Although Vermont's racial and ethnic minority populations are growing, the large majority of Vermonters are white. In 2013, the population distribution by race and ethnicity was estimated as follows:[11]

- 95.2% White
- 1.2% Black or African American
- 0.4% American Indian and Alaska Native
- 1.4% Asian
- 1.8% Multiracial
- 1.7% Hispanic or Latino

Vermont's largest urban area, Chittenden County, is composed of greater racial and ethnic diversity compared to the state:[12]

- 92.2% White
- 2.3% Black or African American
- 0.3% American Indian and Alaska Native
- 3.2% Asian
- 2.0% Multiracial
- 2.0% Hispanic or Latino

Employment. Since July 2013, the Vermont economy has been steadily improving. As of May 2015, Vermont's unemployment rate was 3.6%, compared to a national rate of 5.5%. However, the

[7] Vermont Department of Health. Vermont Population Estimates 2013.
[8] Census Bureau. Growth in Urban Population Outpaces Rest of Nation, Census Bureau Reports. March 26, 2012. https://www.census.gov/newsroom/releases/archives/2010_census/cb12-50.html Accessed June 26, 2015.
[9] Vermont Department of Health. Vermont Population Estimates 2013.
[10] Vermont Behavioral Risk Factor Surveillance System. 2014 Data Summary.
[11] Census Bureau. Quick Facts Vermont. Accessed August 11, 2015.
[12] Census Bureau. Quick Facts Vermont. Accessed August 11, 2015.

unemployment rate varies across counties, ranging from 2.5% in Chittenden County and 5.7% in Essex county, and across towns, ranging from 1.9% in Middlesex up to 17.3% in Killington.[13]

Income. In 2014, Vermont's average annual wage was $43,011, with higher wages in Chittenden County at $49,656 and the lowest wages in Grand Isle County at $31,111.[14] According to the 2014 federal poverty guidelines, an income of $23,850 for a family of four is equal to the federal poverty level (FPL).[15]

Poverty. In 2013, 9% of the Vermont population was under 100% FPL compared to 15% of the U.S. population;[16] and 19% of the Vermont population fell between 100%-199% FPL, equivalent to the U.S. population.[17]

Education. About 91% of Vermonters age 25 and older are high school graduates, compared to 86% of the U.S. population.[18] Just over three in ten (32%) Vermont adults have a college education or higher; four in ten or 39% have a high school education or less.[19]

Insurance Status. Children 0-18 years of age with a family income of 312% FPL are eligible for Medicaid in Vermont. Women who are pregnant with an income up to 208% FPL are eligible for Medicaid in Vermont. Vermont has expanded Medicaid coverage to low-income adults as well, up to 133% FPL.[20] In 2014, 21% or 132,829 Vermonters were insured by Medicaid.[21]

In 2014, it was estimated that 3.7% or 23,000 Vermonters were uninsured. Compared to 2012, the number of Vermont residents reporting no health insurance decreased by about 20,000 individuals (6.8% to 3.7%). About 1,300 of Vermont's uninsured population are under age 18, representing 1% of Vermont's children 0-17 years of age. About 2,900 or 4.6% of young adults 18-24 are uninsured and about 7,900 or 11% of adults 25-34 years of age are uninsured.[22]

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[13] Vermont Department of Labor. Local Area Unemployment Statistics. May 2015.
[14] Vermont Department of Labor. Vermont Quarterly Census of Employment Wages. 2014.
[15] U.S. Department of Health and Human Services. 2014 Federal Poverty Guidelines.
[16] The U.S. Census Bureau's poverty threshold for a family with two adults and one child was $18,751 in 2013.
[17] The Henry J. Kaiser Family Foundation. State Health Facts, Vermont. www.statehealthfacts.org
[18] Census Bureau. Quick Facts Vermont. Accessed June 26, 2015.
[19] Vermont Behavioral Risk Factor Surveillance System. 2014 Data Summary.
[20] Medicaid.gov. Vermont Profile. Accessed September 9, 2015.
[21] Vermont Department of Financial Regulation, Insurance Division. 2014 Vermont Household Health Insurance Survey Research Findings.
[22] Vermont Department of Financial Regulation, Insurance Division. 2014 Vermont Household Health Insurance Survey Research Findings.

Vermont Family Planning & Reproductive Health Overview

Women of Reproductive Age. In 2013 in Vermont, there were 116,335 women of reproductive age (aged 15–44).[23] According to Vermont's Behavioral Risk Factor Surveillance System (BRFSS), a telephone survey conducted annually among adults 18 and older, in 2013:[24]

- 36% of women age 18-44 said a health care professional had ever spoken with them about ways to prepare for a healthy pregnancy and baby.
- 72% of women 18-44 said they used birth control at the last time they had sex. More than a third (36%) said it was a shot, pill, contraceptive patch or a diaphragm; 22% used a permanent method (i.e., sterilization); and 17% used a LARC.
- Women who did not use birth control during their most recent sex indicated most often it was because they were unable to get pregnant (43%) or they were seeking pregnancy (26%).

Births. In 2013, 5,951 babies were born to Vermont residents, representing a birth rate of 51.2 births per 1000 women 15-44 years of age (i.e., fertility rate), a slight decrease from 51.5 in 2012 and 51.6 in 2011. The teen birth rate in Vermont in 2013 was 14.5 births per 1000 women 15-19 years of age, compared to the U.S. rate of 26.5; 317 infants were born to Vermont mothers ages 15-19 in 2013.[25]

Vermont's preterm birth rate in 2013 was 8.1% compared to 11.4% among the U.S. population. Vermont's low birthweight rate in 2013 was 7% compared to 8% among the U.S. population. Vermont's infant mortality rate was 5.0% compared to 6.4% among the U.S. population.[26]

Pregnancy & Unintended Pregnancy. In 2013, the pregnancy rate in Vermont was 61.2 pregnancies per 1,000 women age 15 to 44, a decrease from 61.7 in 2012 and 62.4 in 2011. The 2013 teen pregnancy rate was 21.9 pregnancies per 1,000 women age 15 to 19 years, a decrease from 23.1 in 2012 and 25.2 in 2011. In general the teen pregnancy rate has been decreasing since 1991.[27]

Unintended Pregnancy. The Pregnancy Risk Assessment Monitoring System (PRAMS) helps public health professionals survey the population and track trends over time. The survey is of women who recently gave birth and asks about their experiences and behaviors before, during and shortly after their pregnancy. In 2012, PRAMS indicated that 39.8% of pregnancies among Vermont women who had a live birth were unintended. This is an increase from 2010 and 2011, in which 35.1% and 35.4% of Vermont pregnancies were reported as unintended, respectively. However, of note is a change in the 2012 PRAMS survey question on the intendedness of a pregnancy. The 2012 respondents were given the option of responding to the question with "I wasn't sure what I wanted". This answer option is included as unintended and therefore 2012 data are not directly comparable to previous years.[28]

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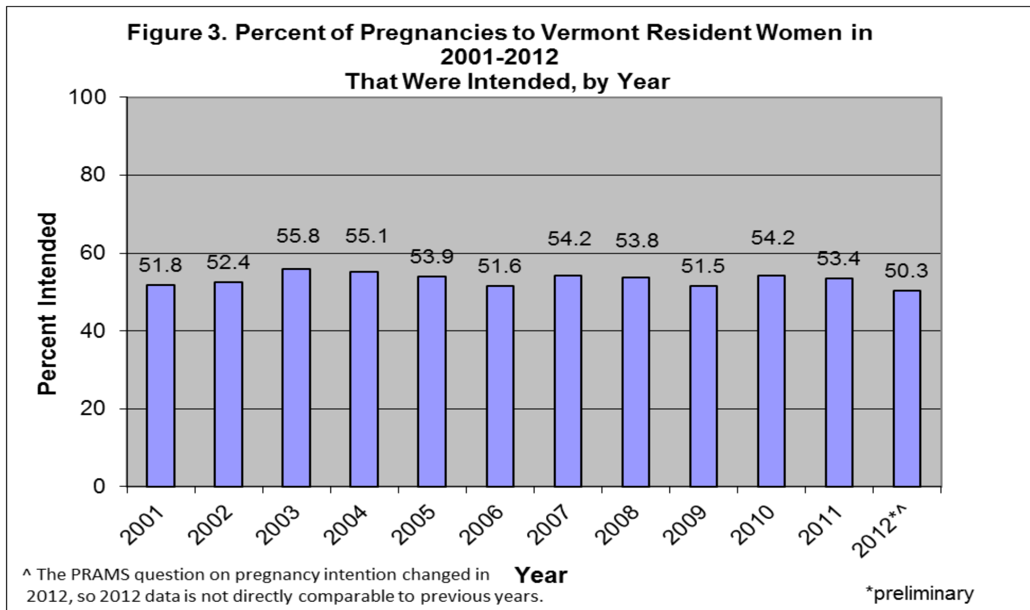
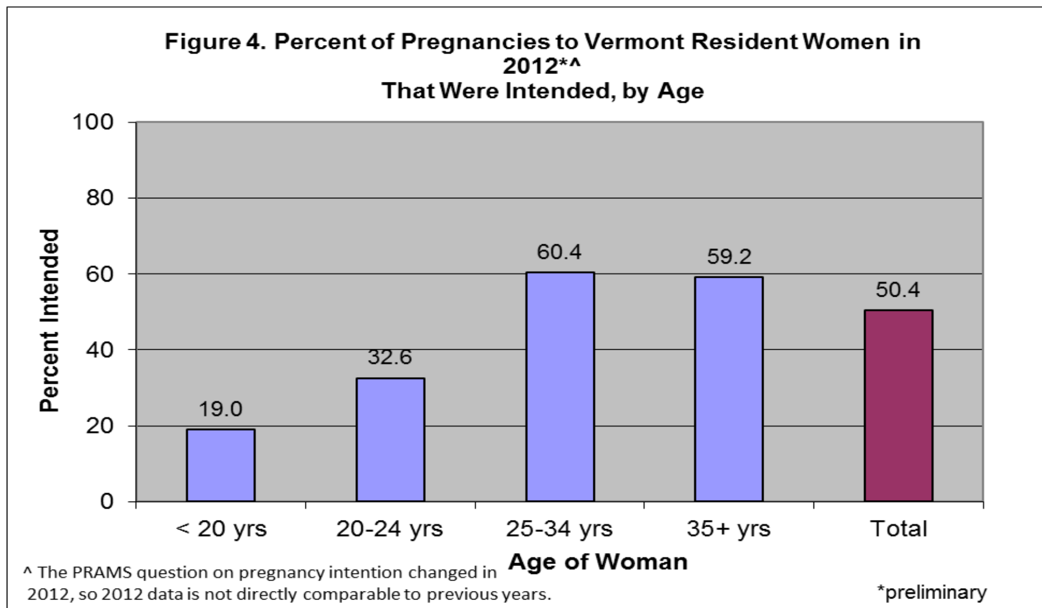
[23] Vermont Department of Health. Vermont Population Estimates 2013.
[24] Vermont Behavioral Risk Factor Surveillance Survey. 2013 Data Summary.
[25] Vermont Department of Health. Vital Statistics. Internal Communication and 2011 Vital Statistics Report.
[26] The Henry J. Kaiser Family Foundation. State Health Facts, Vermont. www.statehealthfacts.org
[27] Vermont Department of Health. Vital Statistics. Internal Communication.
[28] Vermont Department of Health. Pregnancy Risk Assessment Monitoring System. Internal Communication.

Using PRAMS data to estimate the percentage of women with live births who report their pregnancy was intended and applying this to Vermont's vital statistics data on the number of pregnancies, live births, and abortions (considered unwanted pregnancies), intended pregnancies among Vermont women can be further analyzed. Figure 3 displays the percent of pregnancies to Vermont women that were intended, by year, and Figure 4 displays the percent of pregnancies to Vermont women in 2012 that were intended, by age. According to 2012 data, 50.4% of pregnancies to Vermont women were intended relative to the Healthy Vermonters 2020 goal of 65%.[29]





[29] Vermont Department of Health. Pregnancy Risk Assessment Monitoring System and Vital Statistics.

Teen Sexual Behavior, Pregnancy & Birth Rate. In 2013, 43% of high school students in Vermont reported ever having sex and 44% reported ever having oral sex. Among those sexually active, 85% reported using prescription birth control or condoms at last sex. Twenty two percent of students reported using drugs or alcohol at last sex.[30]

Vermont has a relatively low teen pregnancy rate of 22 pregnancies per 1000 women 15-19 years of age, a decrease from 23.1 in 2012 and 25.2 in 2011. In 2013, there were 478 pregnancies to Vermont teens aged 15–19; 317 or 66% resulted in a live birth. Based on this data, the 2013 teen birth rate is 14.5 per 1,000 women 15-19 years of age, a decrease from a rate of 16.3 in 2012 and 16.8 in 2011.[31]

STIs & HIV.

Syphilis[32]

- In Vermont, the rate of primary and secondary syphilis was 1.8 per 100,000 in 2008 and 1.0 per 100,000 in 2012. Vermont ranks 44th in rates of syphilis among the 50 states.
- There were 0 cases of congenital syphilis from 2008 through 2012.

Chlamydia & Gonorrhea[33]

In 2012, Vermont:

- Ranked 46th among 50 states in chlamydial infections (275.2 per 100,000 persons) and ranked 46th among 50 states in gonorrheal infections (15.8 per 100,000 persons).
- Reported rates of chlamydia among women (408.1 cases per 100,000) were 2.9 times greater than those among men (138.6 cases per 100,000).

HIV

- In 2011, an estimated 12 adults and adolescents were diagnosed with HIV in Vermont. Vermont ranked 50th among the 50 states in the number of HIV diagnoses in 2011.[34]
- In 2014, 3 in 10 (31%) of Vermont adults reported every being tested for HIV, with more than half indicating their last HIV test was at a private doctor's office. Adults 25-44 were significantly more likely to have ever been tested for HIV (52%) than other age groups. Six percent of Vermont adults reported HIV testing in the past year.[35]

Family Planning Behaviors & Risk Factors. Understanding family planning behaviors and risk factors that affect reproductive and sexual health help to identify opportunities for prevention, early intervention, and education, particularly for those who experience an unintended pregnancy. The following information is from the 2011 Vermont PRAMS:[36]

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[30] Vermont Youth Risk Behavior Survey. 2013.
[31] Vermont Department of Health. Vital Statistics. Internal Communication and 2011 Vital Statistics Report.
[32] CDC. Vermont—2013 State Health Profile. http://www.cdc.gov/nchhstp/stateprofiles/pdf/Vermont_profile.pdf Accessed July 9, 2015.
[33] CDC. Vermont—2013 State Health Profile. http://www.cdc.gov/nchhstp/stateprofiles/pdf/Vermont_profile.pdf Accessed July 9, 2015.
[34] CDC. Vermont—2013 State Health Profile. http://www.cdc.gov/nchhstp/stateprofiles/pdf/Vermont_profile.pdf Accessed July 9, 2015.
[35] Vermont Behavioral Risk Factor Surveillance System. 201.
[36] Vermont Pregnancy Risk Assessment Monitoring System. 2011.

- Half (49%) of mothers whose pregnancies were unintended reported using any method of birth control.
- Vermont has a relatively high rate of postpartum contraception use compared to other PRAM states; 88% of mothers used contraception after their most recent birth, including 95% of teen mothers.
- Although the Vermont PRAMS survey found a discussion with a health care worker about birth spacing was not associated with the likelihood of using contraception, postpartum contraception use occurred more frequently with women who had talked to a health care worker about a specific method of birth control after delivery. The most common reasons women gave for not using postpartum contraception were abstinence and "don't want to use".

Vermont 2011 PRAMS data indicate the following regarding preconception health:

Multivitamin Use and Weight Gain: 38% of women reported taking a multivitamin every day in the month prior to pregnancy; 19% of mothers age 20 - 24 took a daily multivitamin during the month prior to pregnancy. 23% of mothers were overweight prior to pregnancy, and 20% were obese. 29% of mothers were dieting to lose weight in the year prior to pregnancy, and over half (52%) reported exercising 3 or more times per week.[37]

Alcohol and Tobacco Use: 31% of women smoked in the three months prior to pregnancy; 19% smoked during the last trimester. 67% of women reported drinking at least some alcohol in the 3 months prior to pregnancy; and, 13% of women reported drinking during the last 3 months of their pregnancy, the highest rate reported among states with PRAMS data.[38]

Stress and Abuse: 70% of women reported at least one stressor during the year before giving birth, with 27% reporting at least 3 stressors, and 6% reporting 6 or more.[39]

- 53% reported financial stress
- 29% reported experiencing emotional stress
- 28% reported partner stress
- 20% reported traumatic stress

Intimate Partner Violence. The 2014 Vermont BRFSS survey included questions on intimate partner violence. Responses indicate that 13% of adults said an intimate partner had ever hit, slapped, pushed, kicked or hurt them in any way. Having ever experienced physical abuse by an intimate partner was statistically more common among women at 16% compared to 9% of men. Additionally, 12% of adults said an intimate partner had ever threatened or made them feel unsafe in some way, and 13% said that an intimate partner had ever tried to control their daily activities. These experiences

[37] Vermont Pregnancy Risk Assessment Monitoring System. 2011.
[38] Vermont Pregnancy Risk Assessment Monitoring System. 2011.
[39] Vermont Pregnancy Risk Assessment Monitoring System. 2011.

were also statistically more common among women compared to men, 19% versus 5% and 16 versus 9%, respectively.[40]

Impact of Services Provided by Title X

- In 2013, there were 68,060 women in Vermont in need of *publicly supported* contraceptive services and supplies. Of these, 9,830 were in need of publicly supported services because they were sexually active teenagers and 26,030 because they had incomes below 250% FPL.[41]
- In 2013, Title X family planning services helped women in Vermont avoid 2,000 unintended pregnancies, 1000 unplanned births, and 700 abortions, including 400 pregnancies to teens, 200 births to teens, and 100 abortions to teens.[42]

Vermont's Title X Population

In 2014, PPNNE's Title X network of health centers served 7,796 women and 923 men, for a total of 8,719 residents of Vermont,[43] compared to a total of 8,872 served in 2013.[44] Of the 8,719 clients served in 2014:

- 47% had incomes at or below 100% FPL, 77% had incomes at or below 250% FPL
- 24% were uninsured
- 21% were teens under the age of 20, and
- 11% were men

The following tables further describe the 8,719 Vermont residents served by Title X in 2014.[45]

Table 1. Unduplicated Number of Family Planning Users by Age Group and Sex

Age Group	Female Users	Male Users	Total Users (%)
Under 15	96	4	100 (1%)
15 – 17	799	24	823 (9%)
18 – 19	871	49	920 (11%)
20 – 24	2193	286	2479 (28%)
25 – 29	1556	207	1763 (20%)
30 – 34	899	171	1070 (12%)
35 – 39	521	65	586 (7%)
40 – 44	376	50	426 (5%)
Over 44	485	67	552 (6%)
Total Users	7796	923	8719

[40] Vermont Behavioral Risk Factor Surveillance System. 2014.
[41] Frost JJ, Frohwirth L and Zolna MR, Contraceptive Needs and Services, 2013 Update, New York: Guttmacher Institute, 2015.
[42] Frost JJ, Frohwirth L and Zolna MR, Contraceptive Needs and Services, 2013 Update, New York: Guttmacher Institute, 2015.
[43] Vermont Title X Family Planning Annual Report. Preliminary Data 2014.
[44] Vermont Title X Family Planning Annual Report. 2013.
[45] Vermont Title X Family Planning Annual Report. Preliminary Data 2014.

Table 2. Unduplicated Number of Family Planning Users by Race and Ethnicity

Race	Hispanic or Latino	Not Hispanic or Latino	Unknown/ Not Reported	Total Users (%)
American Indian or Alaska Native	0	11	1	12 (<1%)
Asian	0	44	5	49 (<1%)
Black or African American	5	91	12	108 (1%)
Native Hawaiian or Other Pacific Islander	0	3	0	3 (<1%)
White	63	5109	465	5637 (65%)
More than one race	7	29	4	40 (<1%)
Unknown/not reported	70	2533	267	2870 (33%)
Total Users	145	7820	754	8719

Table 3. Unduplicated Number of Family Planning Users by Income Level

Income Level as a Percentage of the HHS Poverty Guidelines	Number of Users (%)
100% and below	4110 (47%)
101% - 150%	1275 (15%)
151% - 200%	885 (10%)
201% - 250%	433 (5%)
Over 250%	929 (11%)
Unknown / Not Reported	1087 (12%)
Total Users	8719

Table 4. Unduplicated Number of Family Planning Users by Principal Health Insurance Coverage Status

Principal Health Insurance Covering Primary Medical Care	Number of Users (%)
Public Health Insurance	3342 (38%)
Private Health Insurance	3278 (38%)
Uninsured	2099 (24%)
Unknown / Not Reported	0
Total Users	8719

Contraceptive Methods Used. PPNNE health centers provide contraceptive counseling to all clients as part of a family planning visit and/or for all clients at risk for pregnancy. In 2014, 7714 female clients not pregnant or seeking pregnancy were using the following contraceptive methods:[46]

- 53% Moderately effective hormonal method – pill, patch, ring, Depo
- 16% Long-acting reversible contraception (LARC) – IUD or implant
- 3% Permanent sterilization
- 3% Abstinence

Table 5. Unduplicated Number of Female Family Planning Users by Primary Method of Contraception

Primary Contraceptive Method	Total Female Users
Female Sterilization	235
Intrauterine Devise or System	797
Hormonal Implant	445
Hormonal Injection	726
Oral Contraceptive	2918
Contraceptive Patch	139
Vaginal Ring	311
Cervical Cap or Diaphragm	8
Contraceptive Sponge	0
Female Condom	7
Spermicide (used along)	5
Fertility Awareness or Lactational Amenorrhea Method	0
Abstinence	206
Withdrawal or other method	74
Rely on Male Method	
Vasectomy	37
Male Condom	543
No Method	854
Unknown/Not Reported	409
Total Female Users	7714

Similar to national trends, LARC use among Vermonters is growing, particularly among women served by Title X clinics in Vermont. In 2010, 7.2% of the females served by Title X clinics and using contraception reported a LARC as their primary method of contraception. In 2014, LARC use grew to 17.5% among females served by Title X clinics and using contraception (Figure 5.)[47]

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[46] Vermont Title X Family Planning Annual Report. Preliminary Data 2014.

[47] Vermont Title X Family Planning Annual Report. 2010 -2013; Preliminary Data 2014. Denominator excluded female clients reporting pregnant or seeking pregnancy, refraining from sexual intercourse, and whose primary method was unknown.

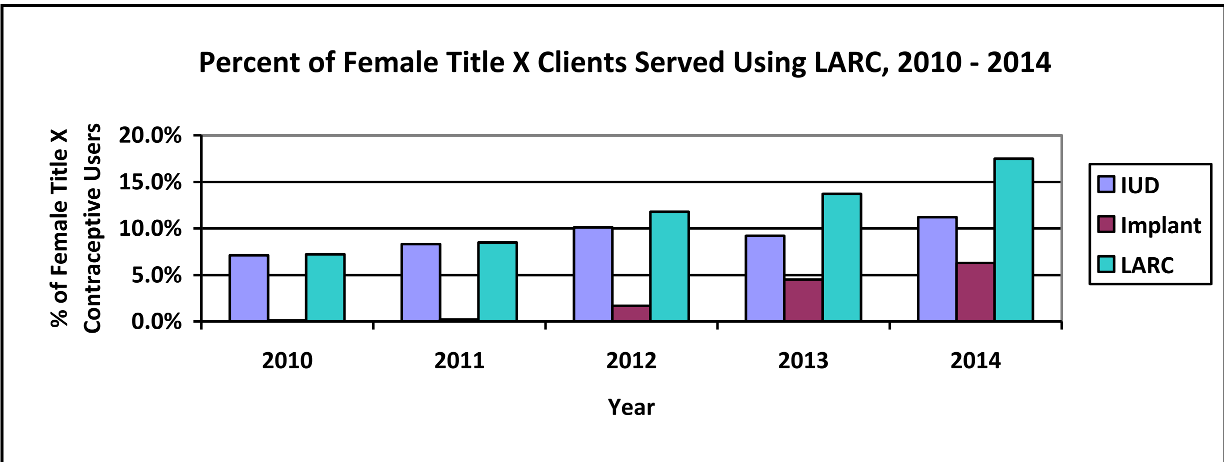

Figure 5. Percent of Title X Female Family Planning Users Reporting use of LARC, 2010 –2014.

In 2014, the 776 male clients not seeking pregnancy were using the following contraceptive methods:[48]

- 65% Male condom
- 1% Vasectomy
- 1% Withdrawal
- 2% Rely on female method

Table 6. Unduplicated Number of Male Family Planning Users by Primary Method of Contraception

Primary Contraceptive Method	Total Male Users
Vasectomy	7
Male Condom	508
Fertility Awareness Method	0
Abstinence	41
Withdrawal or other method	10
Rely on Female Method	14
No Method	136
Unknown/Not Reported	60
Total Male Users	776

STI & HIV Testing. PPNNE provides evidence-based STI screening, testing, and counseling. In 2014, PPNNE Vermont Title X health centers performed the following tests:

- 5,281 Chlamydia tests
- 5,283 Gonorrhea tests
- 1,544 HIV tests
- 403 Syphilis tests

[48] Vermont Title X Family Planning Annual Report. Preliminary Data 2014.

- 1030 HSV tests
- 1544 rapid HIV tests

Furthermore, 60% of all female patients under 25 years of age received a chlamydia test in 2014.

Preventive Health Services. In 2014, 15% of all female clients received a Pap test for cervical cancer screening and 24% received a clinical breast exam.[49]

Findings from the Field

To assess the strengths, challenges, and needs of Vermont's family planning service delivery system, with a particular focus on Title X-funded health centers and services, key informant interviews and discussion groups were conducted with organizations and stakeholders such as PPNNE (e.g., Medical Director, Senior Operations Manager, Director of Government Grants); Vermont's Primary Care Public Health Integration group, Department for Vermont Health Access, and School Liaisons from Vermont's Office of Local Health. A summary of findings and themes related to quality, access, needs, and high priority populations is provided.

Strengths of Vermont's Family Planning System. As the sole Title X provider in Vermont, PPNNE is a valued asset in the state, according to interviewees. PPNNE interviews indicated they provide comprehensive, standardized, high-quality family planning and reproductive health care across all of their health centers throughout the state. To ensure accessible and timely services, health center sites are maintained regionally throughout the state. As a result, access to PPNNE's services is considered strong, even in the very rural parts of the state. Vermont's Medicaid program and the Access Plan further bolster access to family planning services, according to interviewees. The Medicaid income eligibility limit for Vermont adults is 138% FPL and 213% FPL for women who are pregnant.[50] For children 0-18, the Medicaid income eligibility limit is set at 242% FPL and 317% FPL for the Children's Health Insurance Program (CHIP).[51] The Access Plan, sponsored by the Health Department, supports PPNNE's delivery of family planning services to low-income Vermonters living at less than 200% FPL. Interviewees were optimistic that as health care reform is implemented in Vermont, there will increasingly be more people with access to private health insurance and have no cost-sharing for most of the services PPNNE provides (i.e. preventive services).

Vermont has a relatively low number and proportion of uninsured individuals compared to other states and as more become insured, PPNNE expects it will benefit from a business perspective because there will be fewer men and women to cover via a sliding fee. As the health care system in Vermont evolves in response to health care reform, interviewees indicated a need to establish the role of family planning within the strategies for improved population health, which currently focuses on chronic conditions. Interviewees have found it challenging to weave family planning strategies (e.g., LARC) into health reform conversations that focus on exploring high impact opportunities to promote

[49] Vermont Title X Family Planning Annual Report. Preliminary Data 2014.
[50] The Henry J. Kaiser Family Foundation. State Health Facts, Vermont. www.statehealthfacts.org
[51] The Henry J. Kaiser Family Foundation. State Health Facts, Vermont. www.statehealthfacts.org

preventive care and wellness as a mechanism to improve overall population health. One challenge noted is conveying the long-term shared savings from family planning interventions relative to providers being limited to capturing savings from attributable patients. As one interviewee noted, "…the savings needs to be shared more broadly". It was suggested that accountable communities of health may be an opportunity to better address the health impact and savings of family planning strategies within the context of improving population health while reducing costs to the health care system.

To ensure accessible high-quality systems and services, PPNNE shared that they have established practices to monitor, assess and improve their clinical and administrative workflows, workforce capacity, and better address patient needs. Specific initiatives include:

- Transitioning all health centers to an electronic health record system (EHR), with a final rollout to be complete by September 2015.
- Enhanced staffing models (e.g., Health Care Associates), flexible staffing (e.g., telecommute), and telemedicine initiatives (e.g., contraceptive counseling and options, urinary tract infection visit, and STI/HIV screening) to maximize capacity, and to support a feasible and financially sustainable business model, high-quality staffing and retention, and a work environment supportive of work-life balance.
- Rebranding of all health centers to have an aligned look and feel that speaks to the quality of care PPNNE provides. This initiative is intended to support a change in PPNNE's tagline to a provider of choice rather than a provider of last resort. The rebranding initiative is expensive and has been supported by private donations to date.
- Efforts to ensure culturally competent care, such as recruiting a diverse workforce representative of the patient population PPNNE serves, and providing ongoing training of staff to increase culturally competent care (e.g., PPNNE human resources Inclusivity Project).
- Strategic collaboration with community partners to best serve the needs of vulnerable populations (e.g., maintain same day access to services at the St. Albans health center to support needs of population with substance abuse issues).
- Addition of a centralized nurse care coordinator to provide care coordination for clients across PPNNE Vermont health centers and other primary care or specialty providers.

Other strengths reported beyond the Title X funded health centers focused on schools and potential for SBHCs to address sexual and reproductive health. Interviewees reported that Vermont has done good work in HIV and sexuality education within schools using research and evidence-based curricula. PREP and V-SHEP are examples. School Liaisons and school nurses throughout the state make efforts to coordinate with local parent child centers and providers to support students' reproductive and sexual health needs. For example, in Brattleboro the School Liaison makes efforts to coordinate with the local PPNNE health center to facilitate student contraceptive needs; in Morrisville the Coordinated School Health Team is currently focusing on sexuality education across grades K-12. Building on this work, interviewees feel there is further need and opportunity to do more systems-level work to address barriers (e.g., transportation, financial, and attitudes and beliefs on providing sexual and reproductive health education and services within the school setting), and to create linkages between schools, communities, and health care providers in support of student health, including reproductive and sexual health. Interviewees suggested the *Whole School, Whole Community, Whole Child* model

is an opportunity to address student reproductive and sexual health more broadly within schools and communities, as this model emphasizes collaboration among the school, health, and community sectors to improve each child's learning and health.[52]

SBHCs were also noted as strength where they exist in the state. Some health care providers have looked at how SBHCs could provide services for specific areas of need in concert with primary care providers. Burlington High School has a SBHC in which primary care providers see students at the SBHC for acute visits. The providers are currently working more on connecting students with primary care for regular routine visits, such as adolescent health visits. However, providers noted that not all students are receptive to following up with a primary care provider or medical home, and therefor there is need to provide primary care services to students at the SBHC (e.g., vaccines).

The SBHC in St. Albans was indicated as a long-standing example of a SBHC in which a local community provider goes to the high school once a week to see patients to provide health services such as followup on asthma and depression. In Burlington's SBHC, providers find that mental health and behavioral health issues are the most prevalent issues they address with students. Providers work closely with the guidance counselors and the Community Health Team to support student counseling needs. Reproductive health and sexual health services are not currently provided by SBHCs, according to those interviewed.

Challenges for Vermont's Family Planning System. Although PPNNE has implemented several innovative strategies to enhance access to services throughout the state and to target populations, interviewees feel there is room for improving access. They reported that maintaining access in the very rural areas of the state has been difficult due to challenges related to financial sustainability and staff recruitment and retention. Thus, some of PPNNE Vermont health centers are very small and open on a limited basis (e.g., fewer hours and/or days per week).

Interviewees are interested in improving access to services for teens, particularly for teens insured under their parents' health care plans but who may be reluctant to use their insurance due to concerns about confidentiality.

Gaps in access to family planning services were reported for other vulnerable populations in Vermont as well, such as the immigrant and migrant populations, both due to barriers in access related to lack of insurance and barriers related to outreach, engagement, transportation, and health literacy.

Interviewees reported there are gaps in the system on engagement and access for individuals with substance abuse issues. Although PPNNE health centers and community based organizations are making efforts to better reach these individuals to meet their family planning needs, they find it is a difficult population to reach as family planning is often a secondary priority relative to substance use and treatment.

[52] Centers for Disease Control and Prevention. Whole School, Whole Community, Whole Child. http://www.cdc.gov/healthyyouth/wscc/ Accessed October 2, 2015.

Long-Acting Reversible Contraception (LARC). Interviewees felt strongly that increasing awareness, access, and availability to long-acting reversible contraception (LARC) is a key strategy to reducing unintended pregnancy. LARC includes intrauterine devices (IUD) and implants, which are highly effective contraceptive methods for preventing pregnancy. Energy and efforts to improve access to LARC in Vermont, specifically within PPNNE's network of health centers, are felt to have been successful in promoting use of LARC. Interviewees reported the following initiatives have been important factors in improving access and uptake of LARC over recent years:

- All PPNNE clinicians are trained to provide LARC
- A centralized supply chain for LARC ensures adequate supplies at each site to provide same-day services as needed
- Bulk purchase of LARC supports affordability
- Establishing referral relationships and processes with other providers to support access to LARC
- Tiered counseling for all patients promotes awareness and uptake of LARC
- Establishment of a LARC Workgroup (e.g., Health Department, PPNNE, Primary Care Public Health Integration group members, UVM Medical Center Departments of Obstetrics and Gynecology and Family Medicine, and VCHIP)
- Conducting a needs assessment, provider survey and mapping of LARC services in Vermont to inform LARC training to providers. Training will be provided by the Vermont Child Health Improvement Program, a maternal and child health services research and quality improvement program of the University of Vermont.

Remaining barriers and challenges to promoting access and use of LARC were identified and include addressing (1) misperceptions, attitudes, and beliefs on LARC, and (2) the low margins of reimbursement most providers realize for providing LARC, which lends to low financial incentive for promoting provision of LARC. One emerging solution noted to reduce the financial burden of providing LARC is a new alternative IUD, Liletta. PPNNE reported that Liletta is recently available at an improved pricing structure for Title X grantees and FQHCs. PPNNE has replaced the Mirena IUD with Liletta to ease the financial burden of stocking and providing these devices.

Another reported barrier to expanding access to LARC post-partum is the bundled reimbursement mechanism for providing an IUD. In general, both public and private insurers have a global reimbursement rate for hospital care and services during the time of delivery. Provision of LARC post-partum after delivery is included in this bundled rate, resulting in a financial loss to hospitals that provide an IUD post-partum.

As Vermont works to expand access to LARC, particularly for adolescents, interviewees feel that strengthening relationships and referrals from the pediatric community will be important. Interviewees feel the pediatric community is currently not comfortable with providing LARC. PPNNE feels their well-established systems and skilled workforce could serve as an important resource to meet the LARC need among interested Vermont adolescents. In addition to relationship building, it is felt that culture change regarding the perception and role of PPNNE health centers among the medical community will be necessary to facilitate collaborative agreements and referral networks.

The Community Health Centers of Burlington, an FQHC, noted they too have strong systems in place to provide LARC. Staff are trained to provide LARC, including mid-level providers, they stock LARC supplies, and have found they have good uptake of LARC among their patient population.

High Priority Populations. Interviewees noted several populations in Vermont they prioritized as vulnerable and in need of family planning services. These included individuals of low income; teens; men; individuals with mental health and/or substance abuse issues; the lesbian, gay, bisexual, transgender and queer population (LGBTQ); racial and ethnic minorities; and women who are incarcerated.

Low Income. Interviewees indicated that PPNNE health centers serve clients across all incomes, but the majority of their clients are of low income, at or below 100% FPL. Interviewees expressed concern around fully meeting the many social needs of low income clients, which can also influence family planning outcomes. A common example shared was that when impoverished individuals are struggling with food insecurity and housing insecurity, family planning and contraceptive use is not always a priority. To better support client needs beyond family planning and other health care needs, PPNNE is currently working with Vermont's 3 Square Program to establish referrals to and from the Program in an effort to ensure food security among their clients.

Teens. Interviewees indicate need to improve access for teens, particularly teens with health insurance that choose not to use their health insurance for services due to confidentiality concerns. Although this group is a small subset of the population served, PPNNE would like to determine how to best serve this population.

The majority of PPNNE's population served is 16-26 years of age. In their outreach and engagement efforts, PPNNE works to meet teens where they are at, for example, using multiple social media platforms and exploring potential opportunity to use telemedicine to serve teens and mitigate transportation barriers. PPNNE is also starting to work with the school system again and currently has a condom program at their White River Junction site.

Another resource called out to support teens' family planning, reproductive and sexual health needs are SBHCs in Vermont. Interviewees feel they offer an effective mechanism to reach adolescents and provide contraceptive services and/or refer students to other providers to address family planning and other health care needs.

Many interviewees noted concern on maintaining engagement in the health care system as adolescents transition to young adulthood. Continued engagement and use of the health system was indicated as an important facilitator in ensuring continuity of care and preventive care. This is considered important because family planning services are often a primary entry point and use of the health care system for adolescents and young adults, and interviewees indicated that young adults in Vermont experience challenges in obtaining timely access to primary care. Some interviewees felt that integrating well-woman care into family planning and preconception care may be promising strategy to maintain access and engagement in the health system as adolescents transition to adulthood.

Men. PPNNE indicated they are growing the number of male clients served each year, and have made intentional efforts to better reach and serve men. PPNNE's recent rebranding included marketing campaigns inclusive of men (i.e., messaging that in addition to serving women, PPNNE is a place for men to receive high-quality family planning and reproductive health services, too), and the redesign of health centers that are intended to be a comfortable environment for men and women. PPNNE has also tailored services to better reach men and ensure services are inclusive of men's family planning and reproductive health needs (i.e., integrating STI services into patient visits and providing expedited partner treatment).

Interviewees report that men primarily access and use the family planning service delivery system for STI screening. Providers try to segue conversations during visits to talk about contraception, reproductive life planning, and provide some basic primary care (e.g., smoking cessation counseling); transitioning the conversation from STI screening and treatment to reproductive life planning and other health needs can be difficult. Providers feel that until there are more contraceptive options for men, they will continue to serve a much smaller proportion of men than women. Furthermore, PPNNE does not provide vasectomy services, but does offer vasectomy education, counseling, and referral.

In addition to addressing the family planning and reproductive health needs of men, providers would like to expand on the level of education PPNNE provides on intimate partner violence to better reach men. It was suggested that identifying the right community partners may help facilitate this work.

Mental Health/Substance Abuse. Substance abuse was recognized as a growing problem in Vermont and often associated with a transient lifestyle. Interviewees experience that this population can be difficult to reach to address family planning needs because often times substance use or sobriety are deemed a higher priority than family planning and contraception. They would like to determine how to better reach and serve this population. One approach suggested that has been implemented at the St. Albans PPNNE health center is to provide same day access to services and consider how to best offer comprehensive and efficient services within a single visit knowing providers may not see the client again for some time. Furthermore, by coordinating with community-based organizations in select regions, PPNNE has been able to identify how to better serve and meet the needs of this vulnerable population. Regional meetings were coordinated by the Health Department in St. Albans and White River Junction. PPNNE and community-based organization participants found the meetings to be a great help in increasing awareness and building understanding of the services available within communities and the needs of the populations they serve. The Health Department plans to continue coordinating similar meetings in other regions of the state in the future.

LGBTQ. PPNNE interviewees indicated that all providers receive general cultural competency training and training on culturally competent transgender care, lending to an established comfort level with preventive care for transgender among providers. PPNNE's Burlington health center is receiving training to provide trans-care.

Although providers are well-trained to serve the family planning and reproductive health care needs of the LGBTQ population in Vermont, interviewees indicated there is need for more outreach to this population and engagement in the health care system. Additionally, interviewees remarked that while

there are several resources and supports targeting the LGBTQ community within Chittenden County, there are very few in most other parts of the state. This makes it difficult to reach this population as well as provide appropriate supports to this population.

Racial & Ethnic Minorities. As the racial and ethnic minority population in Vermont grows, particularly immigrants and refugees residing in Chittenden County, interviewees are identifying more need to outreach to these populations and to provide culturally sensitive services. For example, providers indicated challenges with addressing family planning needs of some immigrant and refugee patients due to cultural and religious beliefs and attitudes on contraception. The Hispanic/ migrant worker population in Addison County was also called out has a population with unmet health and family planning needs, partly due to cultural barriers and partly due to financial and transportation barriers.

PPNNE interviewees noted efforts to better service racial and ethnic minority populations by way of coordinating with other organizations, including Community Health Centers of Burlington who sees a significant proportion of the immigrant and refugee population in Chittenden County, to establish referrals to PPNNE to serve the family planning and reproductive health needs of this population. PPNNE's Cultural Inclusivity Project has benefited staff in becoming more aware of cultural attitudes, behaviors and beliefs related to family planning. Providers have found their tiered counseling approach works well when broaching contraceptive counseling with the recent immigrant and refugee population. Use of phone interpreters has also facilitated serving the needs of this population.

Incarcerated. Women who are incarcerated in Vermont were noted by PPNNE interviewees as a population of interest with unmet family planning need. The Vermont Department of Corrections reported that approximately 85% (about 850 of 1000 women annually) of their female incarcerated population are 18-44 years of age. PPNNE has initiated conversations with the Department of Corrections to determine if there is a role for PPNNE to support the family planning and reproductive health needs of this population or if there is a better solution to the system.

Considerations

This review of Vermont's family planning system and population needs presents a positive picture overall. Interviewees described a family planning system with high access, high quality, comprehensive services, and a supportive landscape. In addition to the 10 Title X funded health centers, Vermont has a broad network of safety-net providers supporting the health care needs of residents throughout the state. Key health and reproductive health indicators also present a favorable status for Vermonters. Most all Vermonters now have health insurance and Vermont's infant mortality, preterm birth, and low weight birth rates rank lower than national rates. Furthermore, the teen pregnancy rate and fertility rate for Vermont continue to decline and post-partum contraceptive use is high among Vermonters.

Despite these gains, this review indicates remaining challenges for Vermont. The rate of intended pregnancy remains relatively consistent at about 50%, well below the 65% Healthy Vermonters 2020 goal. Furthermore, about half (49%) of mothers whose pregnancies are unintended report using any method of birth control. Alcohol and tobacco use during pregnancy remain consistently high

compared to other states. Several sub-populations of concern were noted as having disparate unmet family planning need due to financial, transportation, and cultural barriers. These sub-populations include adolescents, individuals with mental health and/or substance abuse issues, LGBTQ individuals, and racial and ethnic minorities.

In the context of the gains, strengths, and challenges for Vermont's family planning service delivery system, the following focus areas are called out for consideration and intended to guide future efforts of the Health Department and other family planning programs and stakeholders in Vermont.

I. Assess the financial, service delivery, and access implications due to exclusion of the PPNNE Burlington and Williston health center sites from Title X funding. Interviewees indicated limited understanding as to why the Burlington and Williston sites, which serve the largest number of clients in the state relative to other sites, are not included as Title X sites. There is also uncertainty on whether this exclusion impacts access to services among low-income and other vulnerable populations being served by these sites.

II. Promote awareness, implementation, and adherence to the QFP's evidence-based family planning practice guidelines among providers, family planning programs, and health care organizations in Vermont.
   - Disseminate QFP guidelines and related resources (e.g., job aids, webinars, e-learning courses) to providers, programs and organizations. Refer to OPA's National Family Planning Training Centers for existing resources. Explore dissemination mechanisms such as developing a resource hub for providers to access information, announcements, and tools.
   - Identify, coordinate, and support opportunities for provider education and training on QFP guidelines, with a focus on contraceptive effectiveness counseling and informed choice.

III. Explore implementing a quality improvement initiative within hospital systems and/or health care organizations (e.g., FQHCs) throughout the state to promote access to high-quality family planning services with emphasis on the provider's role in family planning and contraceptive counseling. Providers should offer contraceptive services for women and men who want to prevent pregnancy and space births, including contraceptive counseling services. For individuals who might want to get pregnant in the future and prefer a reversible method of contraception, providers should use a tiered approach to presenting a broad range of contraceptive methods, presenting the most effective methods before less effective methods.[53]
   - Explore the use of family planning quality measures among health care organizations to monitor on an ongoing basis (e.g., percentage of patients using moderately or highly effective contraceptive methods; or percentage of patients using LARC methods). Refer to

[53] Gavin L, Moskosky S, Carter M, et. al. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. MMMR 2014; 63(No. 4).

the QFP and OPA National Family Planning Training Centers for guidance on performance measures.

IV. **Continue to explore how to increase access to LARC in a broader way (e.g., beyond PPNNE's heath centers); support innovations and solutions to promote access and awareness of LARC.**
- Work with Medicaid to establish reimbursement for post-partum provision of IUD
- Coordinate with ACOs to include LARC use as a payment measure
- Assess access and provision of LARC via other safety net providers such as FQHCs and RHCs
- Explore use of quality improvement initiatives with safety net providers (e.g., FQHCs, RHCs) and primary care providers to promote a broad range of contraceptive method availability, and guideline-based contraceptive counseling and education
- Establish collaborative agreements and referrals systems with PPNNE and other safety net providers well-equipped to provide LARC (e.g., Community Health Centers of Burlington)

V. **Facilitate linkages between primary care providers and Title X health centers in Vermont.** Vermont's network of Title X health centers provides access to comprehensive guideline-based family planning services throughout the state. Coordinate with primary care providers and practices, such as community health centers, to better understand: (1) their capacity for providing guideline-based contraceptive services and other family planning services; (2) existing referral systems; and (3) opportunities to support or strengthen referral systems with Title X health centers to ensure access to comprehensive high-quality family planning services and continuity of care.

VI. **Increase provider and consumer knowledge of covered family planning and related preventive health services.** The Affordable Care Act has expanded health payer coverage of contraception and a wide range of preventive services, including well-woman visits (Pap tests, cancer screenings, etc.). To promote high utilization of expanded health care benefits, disseminate information on covered family planning and related preventive health services to providers and consumers throughout Vermont. Explore dissemination and repackaging of existing information and education resources as well as developing resources specific to Vermont's health payer member benefits.

VII. **Explore potential opportunities to address family planning, reproductive, and sexual health needs of adolescents within SBHCs in Vermont.**
- Establish understanding of existing SBHCs in Vermont, including location, model of care, scope of services, and community linkages
- Coordinate with SBHCs to identify prominent family planning, reproductive health, and sexual health needs within communities and related services that could be feasibly integrated into SBHCs scope of services
- Assess other state models of SBHCs and scope of family planning services offered

VIII. Explore opportunities for clinical-community linkages between Vermont Title X health centers and community based organizations to establish family planning—human service referral networks.

- Continue Health Department coordination of regional meetings convening PPNNE Title X sites and community programs and organizations to build awareness and understanding of community specific needs and available resources.
- Establish referral networks of social support services within Title X sites; PPNNE recently added centralized care coordinator may be an opportunity to facilitate this effort
- Identify and reach out to programs or organizations currently working with high priority populations to increase awareness of Title X site family planning services and opportunities for outreach and engagement of priority populations (e.g., DVHA MOMS Program, Howard Center, Pride Center, Vermont Refugee Resettlement Program)

Appendix I: Key Informant Interview Participants & Guides

The following table includes the list of organizations, programs, and groups represented in the series of interviews and discussion groups conducted for the 2015 Title X needs assessment interviews. Examples of the guides used to facilitate discussion during interviews follow.

Title X Needs Assessment Key Informant Groups and Organizations	
1	Community Health Centers of Burlington
2	Department of Vermont Health Access, Integrated Family Services
3	Department of Vermont Health Access, Medicaid Obstetrical and Maternal Support Program
4	Department of Vermont Health Access, Policy
5	Parent Child Centers
6	Planned Parenthood of Northern New England
7	University of Vermont
8	UVM Pediatric Primary Care
9	Vermont Center for Health and Learning
10	Vermont Department of Health School Liaisons
11	Vermont Department of Health, Health Promotion Disease Prevention
12	Vermont Department of Health, Maternal and Child Health
13	Vermont Family Network
14	Vermont Federation of Families for Children's Mental Health
15	Vermont PREP Grantees
16	Vermont Primary Care and Public Health Integration Group

Title V Strengths and Needs Assessment
Key Informant Interview Guide

For the 2015 Title V strengths and needs assessment states must identify 7 among the 15 National Performance Measures they will prioritize to improve the health and wellbeing of Vermont's women, mothers, children and families.

Title V of the Social Security Act reflects our nation's commitment to improving the health and well-being of mothers, children, and their families, and is operationalized through a block grant. Every five years, as a part of the federal Title V Block Grant, states are required to complete a comprehensive assessment of the needs, desired outcomes, and system capacity for the maternal and child health population, including children and youth with special health care needs. The results of this assessment will be used to establish the priorities that will guide our Title V program for the next five years (2015-2020).

Background: This is an exciting time in the field of Maternal and Child Health, as the Title V MCH Block Grant is currently undergoing a transformation. One of the primary goals of this transformation is to demonstrate the vital leadership role that state Title V programs play in assuring and advancing public health systems that address MCH population health needs. To achieve this goal, the federal Maternal and Child Health Bureau has defined a core set of national health priority areas that Title V programs across the country will work on to collectively "move the needle." Fifteen national health priority areas have been identified (see Table 1), from which states must select seven to ten to address through their Title V program along with any state specific priority areas. Collectively, these priority areas represent six MCH population domains: 1) Women/Maternal Health; 2) Perinatal/Infant Health; 3) Child Health; 4) Adolescent Health; 5) CYSHCN; and 6) Cross-cutting or Life course. You have been identified as someone with expertise in the ______________________population domain(s). Throughout the interview, I will be referring to this domain and the corresponding national priority areas (see Tale 1). VDH is also currently conducting their 2015 Title X Needs Assessment. Vermont's Title X program provides high quality clinical family planning (e.g., a broad range of FDA-approved contraceptive methods and related counseling) and related preventive health services, including breast and cervical cancer screening; pregnancy testing and counseling; screening and treatment for sexually transmitted infections (STIs); HIV testing; and other patient education and referrals to women and men in Vermont who would otherwise not have access, with a special focus on low-income and rural populations. You have been identified by VDH as well suited to speak to 1) the ____________ domain to inform the VDH'S 2015 Title V Needs Assessment, and 2) the family planning needs ands and services in Vermont for VDH's 2015 Title X Needs Assessment.

---

1. Let's begin by setting the context for the interview. Can you briefly describe your organization and its role in addressing the needs of Vermont's women, mothers, children and families?
    a. Describe specific programs
    b. Reach/ Population focus
    c. Partnerships across the state

2. Now let's turn to thinking about the quality of the system of care for Vermont's women, mothers, children and families. Components of a quality system include *accessible*, *equitable*, *timely*, *coordinated*, *client-centered*, and *culturally competent* care.
    a. What components of quality are well-addressed within Vermont's current system of services and supports for women, mothers, children and families?
    b. What components of quality could be better addressed within Vermont's current system of services and supports for women, mothers, children and families?

3. Thinking about [population domain] and the corresponding national priority areas identified by the federal Bureau of Maternal of Child Health….

    a. What have been some gains in this area for Vermont?
    b. What have been the challenges?
    c. What do you see as key strategies for addressing this issue?
    d. What would be some challenges encountered?
    e. What are the leverage points/opportunities that exist to address this issue (e.g., existing initiatives, coalitions, etc.)?

4. The sixth population domain is Cross-cutting or Life Course and refers to public health issues that impact multiple MCH population groups such as smoking or oral health. What do you see as significant cross-cutting issues for Vermont's MCH populations? Why?

    a. Cross-cutting or Life Course can also include social determinants of health—how where we live, learn, work and play impacts our overall health and well-being. How do you see social determinants of health playing into the health and well-being of Vermont's women, mothers, children and families?
        i. Which of those that you listed has the greatest impact for [population domain]?

<u>Title X</u>

The U.S. Department of Health and Human Services' Office of Population Affairs (OPA) oversees the Title X program. OPA funds a network of family planning centers which serve about five million clients a year. Services are provided through state, county, and local health departments; community health centers; Planned Parenthood centers; and hospital-based, school-based, faith-based, other private nonprofits. Title X family planning centers provide high quality and cost-effective family planning and related preventive health services for low-income women and men including a broad range of FDA-approved contraceptive methods and related counseling; as well as breast and cervical cancer screening; pregnancy testing and counseling; screening and treatment for sexually transmitted infections (STIs); HIV testing; and other patient education and referrals. Family planning centers play a critical role in ensuring access to voluntary family planning information and services for their clients based on their ability to pay. Every three years states receiving Title X funds are required to conduct a family planning needs assessment. Title X and Title V needs assessment processes overlap for the 2015 cycle. We understand that your work interfaces with the family planning system. We would like to ask you a few questions specific to family planning.

5. Describe your involvement in the family planning system in Vermont?

6. Describe the populations most in need of family planning services in Vermont?

    a. What is Vermont currently doing on outreach and access to best meet the needs of these populations?
    b. Is the system effectively reaching and engaging vulnerable populations?
        i. What are the barriers or challenges to doing so?
        ii. What more could be done to engage vulnerable populations?
    c. What are their most pressing family planning needs?
    d. What more could providers and/or the system be doing?

Recommendations/Closing Observations

7. As we come to the close of our interview, what are the top recommendations you have for ensuring an accessible high-quality system of support and services for Vermont's women, mothers, children and families?

8. Are there any closing observations or thoughts you would like to share regarding ________________ [population domain] and how Vermont can strive to ensure the overall health and well-being of_________________________[population domain]?

Table 1: National Priority Areas by Population Domain

MCH Population Domain	National Priority Area
Women/Maternal Health	Well Woman Care Low Risk Cesarean Deliveries
Perinatal/Infant Health	Perinatal Regionalization Breastfeeding Safe Sleep
Child Health	Developmental Screening Injury Prevention Physical Activity
Adolescent Health	Injury Prevention Physical Activity Bullying Adolescent Well Visit
Children and Youth with Special Health Care Needs	Medical Home Transition
Cross-cutting/Life course	Oral Health Smoking Adequate Insurance Coverage

Vermont Title X Needs Assessment
Key Informant Interview Guide

Background: Title X of the Public Health Service Act is designed to ensure access to comprehensive reproductive health care, with an emphasis on services to lower income women and men. The U.S. Department of Health and Human Services' Office of Population Affairs (OPA) oversees the Title X program. OPA funds a network of family planning centers which serve about five million clients a year. Services are provided through state, county, and local health departments; community health centers; Planned Parenthood centers; and hospital-based, school-based, faith-based, other private nonprofits. In Vermont, Title X services are provided by Planned Parenthood of Northern New England.

The overarching goal of Vermont's Title X program is to provide high quality clinical family planning (e.g., a broad range of FDA-approved contraceptive methods and related counseling) and related preventive health services, including breast and cervical cancer screening; pregnancy testing and counseling; screening and treatment for sexually transmitted infections (STIs); HIV testing; and other patient education and referrals to women and men in Vermont who would otherwise not have access, with a special focus on low-income and rural populations. Specifically, Vermont's Title X program seeks to:

- Reduce unintended pregnancies in Vermont
- Improve access to a broad range of effective contraceptive methods
- Provide access to emergency contraceptive services
- Reduce sexually transmitted diseases
- Promote healthy relationships, healthy sexual behaviors and strengthen community capacity to promote positive reproductive health

Thank you for taking the time to participate in Vermont's 2015 Title X needs assessment process by way of this interview. The information collected from key informants will be used by the Vermont Department of Health's Division of Maternal and Child Health to inform 1) their upcoming application to OPA for continued Title X funding in Vermont, and 2) planning and priorities of their future Title X, family planning, and reproductive-health related work.

---

1. Let's begin by setting the context for the interview. Can you briefly describe your organization and its involvement in the family planning system in Vermont?
    a. Describe specific programs
    b. Reach/ population focus

2. Thinking about Title X and the family planning service delivery system in Vermont, what are the strengths of Vermont's Title X service delivery system and/or existing family planning services?
    a. What have been some of the gains for Vermont in recent years?
    b. To what do you attribute these gains?
    c. What partners are important to expanding or enhancing the Title X service delivery system?

d. Which of these partners do you collaborate/partner with, and how, to meet family planning needs in the state?

3. Similarly, what are some of the barriers or challenges of Vermont's Title X service delivery system and/or existing family planning services?
    a. What are potential strategies to address barriers or challenges of the system?

Access & Quality

4. Describe the populations most in need of family planning services in Vermont?
    a. What are we currently doing on outreach and access to best meet the need(s) of these populations?
    b. What more could providers and/or the system be doing?

5. Is the system adequately reaching the needs of vulnerable populations (e.g., teens, LGBT, racial and ethnic minorities, recent immigrants and refugees)?
    a. Is the system effectively reaching and engaging vulnerable populations?
        i. What are the barriers or challenges to doing so?
        ii. What more could Title X/PPNNE centers and other providers do to engage vulnerable populations?
    b. What are their most pressing family planning needs?

6. Is the system effectively reaching and engaging men?
    a. What are the barriers or challenges to doing so?
    b. What types of services are most commonly delivered to the men served in your program/organization?
    c. What more could Title X/PPNNE centers do to engage men?

7. Now let's turn to thinking about the quality of the family planning service delivery system in Vermont. Components of a quality system include *accessible*, *equitable*, *timely*, *coordinated*, *client-centered*, and *culturally competent* care.
    a. What components of quality are well-addressed within Vermont's current system of family planning and reproductive health care?
    b. What components of quality could be better addressed within Vermont's current system of family planning and reproductive health care?

Long-Acting Reversible Contraceptives (LARCs)

8. To what extent do you feel family planning patients have access to a broad range of contraceptive options, including long acting reversible contraceptives (LARCs)?
    a. What are the primary barriers to promoting use of LARCs to prevent unintended pregnancy?
        i. Provider training and skills to counsel and provide LARCS

ii. Adolescents' knowledge, attitudes, beliefs, and use of LARCs

Preconception Health & Related Preventive Health Services

9. Promoting preconception health and reproductive health planning are important components of family planning, as they influence birth outcomes and men and women's health in general. How does Vermont's family planning service delivery system fair in regard to providing recommended preconception health services (i.e., per USPSTF recommendations)?
    a. What are some of the challenges or barriers to doing so?

10. The family planning service delivery system is often a point of access into the health care system for many women and men, and therefore presents an important opportunity to provide or refer for other related preventive health care services (e.g., cervical cancer screening, breast cancer screening). Similar to the previous question, how does Vermont's family planning service delivery system fair in regard to providing or referring clients for other preventive health services?
    a. What are some of the challenges or barriers to doing so?

11. To wrap up our discussion, what are the top recommendations you have for ensuring an accessible high-quality system of family planning and reproductive health in Vermont?

From: Diamond, Joshua
To: Clark, Charity
Cc: Spottswood, Eleanor
Subject: RE: Title X stats and clinic locations
Date: Wednesday, July 11, 2018 9:23:04 PM

Charity,

Do you want to wait until we hear from planned parenthood first before considering other sites?

Josh

Joshua R. Diamond, Deputy Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, Vermont 05609
802-828-3175
joshua.diamond@vermont.gov

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From: Clark, Charity
Sent: Wednesday, July 11, 2018 7:17 PM
To: Diamond, Joshua <Joshua.Diamond@vermont.gov>
Cc: Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Subject: Fwd: Title X stats and clinic locations

Perhaps we should have the press conference at one of these Title X health centers? None are in Burlington, but one is in St. Albans and another in Barre.

Charity

Sent from my iPhone

Begin forwarded message:

From: "Spottswood, Eleanor" <Eleanor.Spottswood@vermont.gov>
Date: July 11, 2018 at 5:57:42 PM EDT
To: "Clark, Charity" <Charity.Clark@vermont.gov>
Subject: Title X stats and clinic locations

Charity-

For future reference: this is the most recent document with Vermont-specific Title X data in it. A (rough) map of all the Title X clinic locations is on pdf page 9.

Thanks for your help today!

Ella

Eleanor L.P. Spottswood
Assistant Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, Vermont 05609
802-828-3178
eleanor.spottswood@vermont.gov

From:	Diamond, Joshua
To:	Clark, Charity
Subject:	FW: Title X press conference, 7/18 @ 10:00am
Date:	Thursday, July 12, 2018 2:48:31 PM

Charity,

Please see below.   I've been in touch with Eileen and will fill you in later today.

Hope Newport went well.

Best, Josh

Joshua R. Diamond, Deputy Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, Vermont 05609
802-828-3175
joshua.diamond@vermont.gov

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From: Sullivan, Eileen <Eileen.Sullivan@ppnne.org>
Sent: Thursday, July 12, 2018 10:52 AM
To: Diamond, Joshua <Joshua.Diamond@vermont.gov>
Subject: Title X press conference, 7/18 @ 10:00am

Good morning Josh,

My name is Eileen and I work with Lucy at Planned Parenthood. She asked that I reach out to you to discuss a venue for the Title X press conference, which is tentatively scheduled for 10:00am on Wednesday, July 18th.

Do you have time today for a quick phone conversation? Let me know, and many thanks!

Eileen

Eileen Sullivan (She/Her/Hers)
Communications Director, Vermont
Planned Parenthood of Northern New England
784 Hercules Drive, Suite 110
Colchester, Vermont 05446
O: 802-448-9714 | C: 646-467-0674
www.ppnne.org | Eileen.Sullivan@ppnne.org

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From:	Diamond, Joshua
To:	Clark, Charity
Subject:	Fwd: Title X press conference, 7/18 @ 10:00am
Date:	Thursday, July 12, 2018 4:12:54 PM

FYI

Sent from my iPhone

Begin forwarded message:

From: "Sullivan, Eileen" <Eileen.Sullivan@ppnne.org>
Date: July 12, 2018 at 3:51:25 PM EDT
To: "joshua.diamond@vermont.gov" <joshua.diamond@vermont.gov>
Subject: FW: Title X press conference, 7/18 @ 10:00am

Hi again Josh,

It was so nice to talk with you on the phone earlier! Right now, I'd like to tentatively propose our office space in Colchester for the press conference on Wednesday, July 18th. I'm reaching out to the health center site manager to talk about the possibility of our Williston health center as a venue. As discussed, patient privacy could be an issue even if we're outdoors, but we'll see. Our health center in Burlington has virtually no outdoor space – just a sidewalk, so I'm not sure that will work well.

But we'll have our offices at 784 Hercules Drive in Colchester if we're not able to find another appropriate location.

Have a wonderful trip to RI!

Eileen

Eileen Sullivan (She/Her/Hers)
Communications Director, Vermont
Planned Parenthood of Northern New England
784 Hercules Drive, Suite 110
Colchester, Vermont 05446
O: 802-448-9714 | C: 646-467-0674
www.ppnne.org | Eileen.Sullivan@ppnne.org

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From: Clark, Charity
To: Diamond, Joshua
Subject: Re: Title X press conference, 7/18 @ 10:00am
Date: Thursday, July 12, 2018 4:50:00 PM

Sounds fine to me. We will need the media advisory to go out on Monday, so just need to make a location decision by then.
Charity

Sent from my iPhone

On Jul 12, 2018, at 4:12 PM, Diamond, Joshua <Joshua.Diamond@vermont.gov> wrote:

> FYI
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> > **From:** "Sullivan, Eileen" <Eileen.Sullivan@ppnne.org>
> > **Date:** July 12, 2018 at 3:51:25 PM EDT
> > **To:** "joshua.diamond@vermont.gov"
> > <joshua.diamond@vermont.gov>
> > **Subject: FW: Title X press conference, 7/18 @ 10:00am**
> >
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> > But we'll have our offices at 784 Hercules Drive in Colchester if we're not able to find another appropriate location.
> >
> > Have a wonderful trip to RI!
> >
> > Eileen
> >
> > **Eileen Sullivan (She/Her/Hers)**
> > Communications Director, Vermont
> > Planned Parenthood of Northern New England
> > 784 Hercules Drive, Suite 110

Colchester, Vermont 05446
O: 802-448-9714 | C: 646-467-0674
www.ppnne.org | Eileen.Sullivan@ppnne.org

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From:	Diamond, Joshua
To:	Sullivan, Eileen
Cc:	Clark, Charity
Subject:	RE: Title X press conference, 7/18 @ 10:00am
Date:	Friday, July 13, 2018 8:09:03 AM

Eileen,

The Colchester facility will work fine on our end. I'm "cc"ing our Chief of Staff, Charity Clark, on this e-mail as she will be handling the coordination of the press conference.

Best, Josh

Joshua R. Diamond, Deputy Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, Vermont 05609
802-828-3175
joshua.diamond@vermont.gov

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From: Sullivan, Eileen <Eileen.Sullivan@ppnne.org>
Sent: Thursday, July 12, 2018 3:51 PM
To: Diamond, Joshua <Joshua.Diamond@vermont.gov>
Subject: FW: Title X press conference, 7/18 @ 10:00am

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From:	Sullivan, Eileen
To:	Diamond, Joshua
Cc:	Clark, Charity
Subject:	RE: Title X press conference, 7/18 @ 10:00am
Date:	Friday, July 13, 2018 8:54:54 AM

Thank you so much, Josh!

Charity, it's very nice to e-meet you! I'll be in touch to confirm the location of the press conference, and please don't hesitate to call me on my cell at 646-467-0674 if there is anything you need or would like to discuss.

Eileen

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www.ppnne.org | Eileen.Sullivan@ppnne.org

From: Diamond, Joshua [mailto:Joshua.Diamond@vermont.gov]
Sent: Friday, July 13, 2018 8:09 AM
To: Sullivan, Eileen
Cc: Clark, Charity
Subject: RE: Title X press conference, 7/18 @ 10:00am

Eileen,

The Colchester facility will work fine on our end. I'm "cc"ing our Chief of Staff, Charity Clark, on this e-mail as she will be handling the coordination of the press conference.

Best, Josh

Joshua R. Diamond, Deputy Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, Vermont 05609
802-828-3175
joshua.diamond@vermont.gov

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Hi again Josh,

It was so nice to talk with you on the phone earlier! Right now, I'd like to tentatively propose our office space in Colchester for the press conference on Wednesday, July 18th. I'm reaching out to the health center site manager to talk about the possibility of our Williston health center as a venue. As discussed, patient privacy could be an issue even if we're outdoors, but we'll see. Our health center in Burlington has virtually no outdoor space – just a sidewalk, so I'm not sure that will work well.

But we'll have our offices at 784 Hercules Drive in Colchester if we're not able to find another appropriate location.

Have a wonderful trip to RI!

Eileen

Eileen Sullivan (She/Her/Hers)
Communications Director, Vermont
Planned Parenthood of Northern New England
784 Hercules Drive, Suite 110
Colchester, Vermont 05446
O: 802-448-9714 | C: 646-467-0674
www.ppnne.org | Eileen.Sullivan@ppnne.org

From: Sullivan, Eileen
Sent: Thursday, July 12, 2018 10:52 AM
To: 'joshua.diamond@vermont.gov'
Subject: Title X press conference, 7/18 @ 10:00am

Good morning Josh,

My name is Eileen and I work with Lucy at Planned Parenthood. She asked that I reach out to you to discuss a venue for the Title X press conference, which is tentatively scheduled for 10:00am on

Wednesday, July 18th.

Do you have time today for a quick phone conversation? Let me know, and many thanks!

Eileen

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From:	Clark, Charity
To:	Spottswood, Eleanor
Cc:	Wemple, Doug
Subject:	RE: Title X rules page press conference
Date:	Monday, July 16, 2018 10:59:00 AM

Hi, Ella,

How are you coming on a draft press release for Wednesday's press conference?

Thanks,
Charity

From: Clark, Charity
Sent: Tuesday, July 10, 2018 2:58 PM
To: Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>
Cc: Wemple, Doug <Doug.Wemple@partner.vermont.gov>
Subject: RE: Title X rules page press conference

Thanks, Ella! Definitely invite Hannah. I will let you know when we have a firm date, time, and location, but I am going to try hard to stick to 7/18 since there is a deadline for the comment period for these rules.

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Josh and I had discussed maybe getting someone from legislative leadership to be present at the press conference—not sure if that was intended as a speaking role.

I'm pretty new to the area so I still don't know all of the players that I should.

Also—my intern, Hannah Clarisse, has helped me out with some research for this project, so I am going to invite her to attend the press conference as well.

Ella

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Charity

Charity R. Clark
Chief of Staff
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109 State Street

Montpelier, Vermont 05609
802-828-3737

From:	Spottswood, Eleanor
To:	Clark, Charity
Cc:	Wemple, Doug
Subject:	RE: Title X rules page press conference
Date:	Monday, July 16, 2018 11:29:16 AM
Attachments:	Title X Press Release.docx

Hi Charity,

This is pretty long, but hopefully it gives you some language to work with? There is plenty more to say about the rules if you need more language options, too.

Ella

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Sent: Monday, July 16, 2018 10:59 AM
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STATE OF VERMONT
OFFICE OF THE ATTORNEY GENERAL
109 STATE STREET
MONTPELIER, VT 05609-1001

FOR IMMEDIATE RELEASE: CONTACT: [NAME]
[DATE] [TITLE]
[PHONE]

Commented [SE1]: I'm happy to be the contact, or happy to have Charity do it. Either way.

REPRODUCTIVE HEALTH CLINICS JEOPARDIZED BY PROPOSED FEDERAL REGULATIONS

Donovan calls on Vermonters to help protect reproductive health care as we know it

MONTPELIER – The U.S. Department of Health and Human Services (HHS) is trying to defund organizations, such as Planned Parenthood, that provide reproductive health care to low-income people. It is writing new rules for distributing money from Title X, the only nationwide program for affordable birth control and reproductive health care. Attorney General T.J. Donovan opposes these changes and calls on Vermonters to oppose them, too.

"Title X clinics provide essential health care to low-income Vermonters," Donovan said. "These new rules are based on politics, not health care. That's why I've created a website for Vermonters to tell HHS that these rules are bad for Vermont."

Vermont has relied on funding from Title X for decades. Title X funds basic health care services, including wellness exams, cervical and breast cancer screenings, birth control, contraception education, and testing for sexually transmitted diseases and HIV. As a result of the new regulations, however, Title X providers will be forced to give incomplete and misleading information to patients—a "gag rule" on providing services or information related to abortion, even to patients who affirmatively say that they want one. But the rules don't stop there. The gag rule would also apply to any "referral partners" of Title X clinics. And, the new rules stretch Title X funding to try to cover gap in health care created by employers who opt out of providing insurance to cover contraception. The new rules also redefine "family planning" itself to promote

"natural family planning methods" over more effective forms of birth control. The new rules never mention the CDC's evidence-based best practices guidelines, "Providing Quality Family Planning Services," which was the gold standard for health care under the old Title X regulations.

Vermont has ten clinics supported by Title X funds, located in Barre, Bennington, Brattleboro, Hyde Park, Rutland, Middlebury, Newport, St. Albans, St. Johnsbury, and White River Junction. All provide crucial basic health care to underserved populations. Funding for each of these clinics is jeopardized by the new rules.

"It's important that the federal government hear from people whose lives will be affected by these rule changes. And, it's important that the federal government hear from people who support evidence-based health care," Donovan said. HHS is accepting public comments on the new rules only until July 31.

Vermonters who are concerned about the impact of these regulations can get more information and submit comments through a website set up by the Attorney General's Office: http://ago.vermont.gov/act_now_for_womens_health/

More information about the changes to Title X can be found at the independent Guttmacher Institute: https://www.guttmacher.org/article/2018/06/domestic-gag-rule-and-more-administrations-proposed-changes-title-x

# # #

From:	Spottswood, Eleanor
To:	Clark, Charity
Cc:	Wemple, Doug
Subject:	RE: Title X rules page press conference
Date:	Monday, July 16, 2018 11:34:41 AM

In addition to Aki Soga at BFP, it looks like Elizabeth Hewitt at VTD has already done some reporting on this issue: https://vtdigger.org/2018/05/20/trump-rule-change-hit-planned-parenthood-vermont/

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From:	Spottswood, Eleanor
To:	Clark, Charity
Cc:	Wemple, Doug
Subject:	RE: Title X rules page press conference
Date:	Monday, July 16, 2018 11:37:58 AM

Also, Bob Audette at the Brattleboro Reformer and Galen Ettlin at WCAX
https://www.reformer.com/stories/title-x-changes-could-hurt-poorest-residents,541647
http://www.wcax.com/content/news/Local-impacts-of-Title-X-proposal-483074881.html

Sorry for all the emails.

From: Spottswood, Eleanor
Sent: Monday, July 16, 2018 11:35 AM
To: Clark, Charity <Charity.Clark@vermont.gov>
Cc: Wemple, Doug <Doug.Wemple@partner.vermont.gov>
Subject: RE: Title X rules page press conference

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Chief of Staff
Office of the Attorney General
109 State Street
Montpelier, Vermont 05609
802-828-3737

From:	Sullivan, Eileen
To:	Clark, Charity
Cc:	Leriche, Lucy Rose
Subject:	Press conference at 11am on Wednesday, July 18th at Planned Parenthood
Date:	Monday, July 16, 2018 12:39:35 PM

Hi Charity,

So nice speaking with you earlier!

For today's media advisory, can you please include Meagan Gallagher, CEO and President of Planned Parenthood of Northern New England, as the speaker in addition to Attorney General Donovan? She is confirmed. I'll keep you posted on whether or not we're able to secure a health care provider to speak as well.

So we're confirmed for 11am on Wednesday, July 18th at Planned Parenthood of Northern New England, 784 Hercules Drive, in Colchester. We can use our podium, and broadcast crews can clamp their microphones to it.

I hope this is helpful to you, and please let me know if you need any additional info at this time!

Many thanks,

Eileen

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From:	Clark, Charity
To:	Sullivan, Eileen
Cc:	Leriche, Lucy Rose
Subject:	RE: Press conference at 11am on Wednesday, July 18th at Planned Parenthood
Date:	Monday, July 16, 2018 1:00:00 PM

Thanks, Eileen. Sounds great. I will send out the media advisory now.

Please let me know if PPNNE would like to include a quote in our press release. My aim is to have the press release wrapped up by tomorrow afternoon. Our practice is to send out press releases immediately following press conferences, so this release won't go out until after the conference. But it would be nice to have it all lined up and ready to go!

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From:	Clark, Charity
To:	[redacted]
Subject:	MEDIA ADVISORY: AG Donovan to announce website on rule change affecting reproductive healthcare
Date:	Monday, July 16, 2018 1:10:00 PM
Attachments:	Title X Media Advisory.pdf

MEDIA ADVISORY
7/18/18
11:00am

AG DONOVAN TO ANNOUNCE WEBSITE ON RULE CHANGE AFFECTING REPRODUCTIVE HEALTHCARE

WHAT: **Press conference**

AG Donovan will announce the launch of a website for collecting feedback from Vermonters on the Trump Administration's proposed rule change to Title X funding. Title X is a nationwide program that provides healthcare funding to low-income populations. Vermont has 10 clinics throughout the State that are supported by Title X funds.

Joining AG Donovan will be Meagan Gallagher, CEO and President of Planned Parenthood of Northern New England.

WHEN: Wednesday, July 18 @ 11:00 am

WHERE: Planned Parenthood, 784 Hercules Drive, Colchester, Vermont

###

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Chief of Staff
Office of the Attorney General
109 State St.
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7/18/18
11:00am

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WHEN: Wednesday, July 18 @ 11:00 am

WHERE: Planned Parenthood, 784 Hercules Drive, Colchester, Vermont

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From:	Sullivan, Eileen
To:	Clark, Charity
Cc:	Leriche, Lucy Rose
Subject:	RE: Press conference at 11am on Wednesday, July 18th at Planned Parenthood
Date:	Monday, July 16, 2018 3:27:53 PM

Hi Charity,

Thank you so much for sending out the advisory! We absolutely would like to include a quote in the press release and I will send it to you as soon as possible.

Many thanks!

Eileen

Eileen Sullivan (She/Her/Hers)
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From:	Clark, Charity
To:	ehewitt@vtdigger.org
Subject:	FW: MEDIA ADVISORY: AG Donovan to announce website on rule change affecting reproductive healthcare
Date:	Tuesday, July 17, 2018 11:35:00 AM
Attachments:	Title X Media Advisory.pdf

Hi, Elizabeth,

Since I know this topic has been an area of interest in the past, I wanted to flag for Vt Digger the media advisory that went out yesterday. The Attorney General will be having a press conference tomorrow morning at 11 a.m. regarding our launch of a website concerning Title X. I hope you can make it. Please let me know if you have any questions. I can be reached today in my office or tomorrow on my cell (802-917-1993).

Thank you,
Charity

Charity R. Clark
Chief of Staff
Office of the Attorney General
109 State St.
Montpelier, Vermont 05609
802-828-3737

MEDIA ADVISORY
7/18/18
11:00am

AG DONOVAN TO ANNOUNCE WEBSITE ON RULE CHANGE AFFECTING REPRODUCTIVE HEALTHCARE

WHAT: **Press conference**

AG Donovan will announce the launch of a website for collecting feedback from Vermonters on the Trump Administration's proposed rule change to Title X funding. Title X is a nationwide program that provides healthcare funding to low-income populations. Vermont has 10 clinics throughout the State that are supported by Title X funds.

Joining AG Donovan will be Meagan Gallagher, CEO and President of Planned Parenthood of Northern New England.

WHEN: Wednesday, July 18 @ 11:00 am

WHERE: Planned Parenthood, 784 Hercules Drive, Colchester, Vermont

###

From:	Clark, Charity
To:	info@lcatv.org; rebecca@lcatv.org
Subject:	FW: MEDIA ADVISORY: AG Donovan to announce website on rule change affecting reproductive healthcare
Date:	Tuesday, July 17, 2018 11:41:00 AM
Attachments:	Title X Media Advisory.pdf

Hi, Rebecca,

Please find the media advisory attached. The press conference will be tomorrow at 11 a.m. at 784 Hercules Drive, Colchester. If you have any questions, please let me know. I can be reached at my office today or tomorrow on my cell 802-917-1993.

Thanks!
Charity

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WHEN: Wednesday, July 18 @ 11:00 am

WHERE: Planned Parenthood, 784 Hercules Drive, Colchester, Vermont

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From:	Clark, Charity
To:	Goswami, Neal
Subject:	FW: MEDIA ADVISORY: AG Donovan to announce website on rule change affecting reproductive healthcare
Date:	Tuesday, July 17, 2018 11:46:00 AM
Attachments:	Title X Media Advisory.pdf

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109 State St.
Montpelier, Vermont 05609
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MEDIA ADVISORY
7/18/18
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WHEN: Wednesday, July 18 @ 11:00 am

WHERE: Planned Parenthood, 784 Hercules Drive, Colchester, Vermont

###

From:	Clark, Charity
To:	Sullivan, Eileen
Subject:	RE: Press conference at 11am on Wednesday, July 18th at Planned Parenthood
Date:	Tuesday, July 17, 2018 12:21:00 PM

Hi, Eileen,

Just checking in on that quote. Please send it along when it's ready.

I have placed follow-up calls with the TV stations and with some reporters who have followed this issue to flag our media advisory. Fingers crossed for a good turnout so we can spread the word about this website!

Charity

From: Sullivan, Eileen <Eileen.Sullivan@ppnne.org>
Sent: Monday, July 16, 2018 3:28 PM
To: Clark, Charity <Charity.Clark@vermont.gov>
Cc: Leriche, Lucy Rose <Lucy.Leriche@ppnne.org>
Subject: RE: Press conference at 11am on Wednesday, July 18th at Planned Parenthood

Hi Charity,

Thank you so much for sending out the advisory! We absolutely would like to include a quote in the press release and I will send it to you as soon as possible.

Many thanks!

Eileen

Eileen Sullivan (She/Her/Hers)
Communications Director, Vermont
Planned Parenthood of Northern New England
784 Hercules Drive, Suite 110
Colchester, Vermont 05446
O: 802-448-9714 | C: 646-467-0674
www.ppnne.org | Eileen.Sullivan@ppnne.org

From: Clark, Charity [mailto:Charity.Clark@vermont.gov]
Sent: Monday, July 16, 2018 1:01 PM
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From:	Sullivan, Eileen
To:	Clark, Charity
Subject:	RE: Press conference at 11am on Wednesday, July 18th at Planned Parenthood
Date:	Tuesday, July 17, 2018 12:27:19 PM

Thank you so much for the update, Charity! I hope to have the approved quote to you sooner rather than later!! What is your hard-stop deadline?

And ditto, fingers crossed for a great media turnout!

Eileen

From: Clark, Charity [mailto:Charity.Clark@vermont.gov]
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Eileen

Eileen Sullivan (She/Her/Hers)
Communications Director, Vermont
Planned Parenthood of Northern New England
784 Hercules Drive, Suite 110
Colchester, Vermont 05446

From: Clark, Charity
To: Sullivan, Eileen
Subject: RE: Press conference at 11am on Wednesday, July 18th at Planned Parenthood
Date: Tuesday, July 17, 2018 12:53:00 PM

We can add the quote as late as tomorrow morning, so not a big deal if you can't get it to me today. Thanks!

From: Sullivan, Eileen <Eileen.Sullivan@ppnne.org>
Sent: Tuesday, July 17, 2018 12:27 PM
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Subject: RE: Press conference at 11am on Wednesday, July 18th at Planned Parenthood

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From:	Sullivan, Eileen
To:	Clark, Charity
Subject:	RE: Press conference at 11am on Wednesday, July 18th at Planned Parenthood
Date:	Tuesday, July 17, 2018 12:58:26 PM

Hi again, Charity. For the remarks tomorrow, do you know if T.J. is providing a brief overview of what Title X is?

Below is how the remarks for Meagan are shaping up:

Thank you, T.J.
Brief overview of PPNNE, Title X, and Title X in VT (we are the only Title X provider in the state)
Proposed Title X changes by the administration and what they could do
Patient story
Call to action

Is any of this information going to repeat what T.J. will be saying?

Many thanks for any info you're able to share!

Eileen

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From:	Clark, Charity
To:	Sullivan, Eileen
Subject:	RE: Press conference at 11am on Wednesday, July 18th at Planned Parenthood
Date:	Tuesday, July 17, 2018 12:59:00 PM

Eileen,
Give a ring when you have a moment: 802-828-3737.
Speak soon!
Charity

From: Sullivan, Eileen <Eileen.Sullivan@ppnne.org>
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To: Clark, Charity <Charity.Clark@vermont.gov>
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From:	Sullivan, Eileen
To:	Clark, Charity
Subject:	RE: Press conference at 11am on Wednesday, July 18th at Planned Parenthood
Date:	Tuesday, July 17, 2018 1:51:06 PM

Hi Charity,

Quick question – will you have a dedicated web address to announce tomorrow, or should we say to visit the "Attorney General's website at ago.vermont.gov…"?

Many thanks,

Eileen

From: Clark, Charity [mailto:Charity.Clark@vermont.gov]
Sent: Tuesday, July 17, 2018 1:00 PM
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Date:	Tuesday, July 17, 2018 1:53:00 PM

Our press releases can be found here: http://ago.vermont.gov/blog/category/press-releases/ We will upload our press conference tomorrow directly following the press conference.

The designated survey page will be: http://ago.vermont.gov/act_now_for_reproductive_health/ Note that we won't be making this live until the press conference, so it won't work for you today.

Charity

From: Sullivan, Eileen <Eileen.Sullivan@ppnne.org>
Sent: Tuesday, July 17, 2018 1:51 PM
To: Clark, Charity <Charity.Clark@vermont.gov>
Subject: RE: Press conference at 11am on Wednesday, July 18th at Planned Parenthood

Hi Charity,

Quick question – will you have a dedicated web address to announce tomorrow, or should we say to visit the "Attorney General's website at ago.vermont.gov…"?

Many thanks,

Eileen

From: Clark, Charity [mailto:Charity.Clark@vermont.gov]
Sent: Tuesday, July 17, 2018 1:00 PM
To: Sullivan, Eileen
Subject: RE: Press conference at 11am on Wednesday, July 18th at Planned Parenthood

Eileen,
Give a ring when you have a moment: 802-828-3737.
Speak soon!
Charity

From: Sullivan, Eileen <Eileen.Sullivan@ppnne.org>
Sent: Tuesday, July 17, 2018 12:58 PM
To: Clark, Charity <Charity.Clark@vermont.gov>
Subject: RE: Press conference at 11am on Wednesday, July 18th at Planned Parenthood

Hi again, Charity. For the remarks tomorrow, do you know if T.J. is providing a brief overview of what Title X is?

Below is how the remarks for Meagan are shaping up:

Thank you, T.J.
Brief overview of PPNNE, Title X, and Title X in VT (we are the only Title X provider in the state)
Proposed Title X changes by the administration and what they could do
Patient story
Call to action

Is any of this information going to repeat what T.J. will be saying?

Many thanks for any info you're able to share!

Eileen

From: Clark, Charity [mailto:Charity.Clark@vermont.gov]
Sent: Tuesday, July 17, 2018 12:21 PM
To: Sullivan, Eileen
Subject: RE: Press conference at 11am on Wednesday, July 18th at Planned Parenthood

Hi, Eileen,

Just checking in on that quote. Please send it along when it's ready.

I have placed follow-up calls with the TV stations and with some reporters who have followed this issue to flag our media advisory. Fingers crossed for a good turnout so we can spread the word about this website!

Charity

From: Sullivan, Eileen <Eileen.Sullivan@ppnne.org>
Sent: Monday, July 16, 2018 3:28 PM
To: Clark, Charity <Charity.Clark@vermont.gov>
Cc: Leriche, Lucy Rose <Lucy.Leriche@ppnne.org>
Subject: RE: Press conference at 11am on Wednesday, July 18th at Planned Parenthood

Hi Charity,

Thank you so much for sending out the advisory! We absolutely would like to include a quote in the press release and I will send it to you as soon as possible.

Many thanks!

Eileen

Eileen Sullivan (She/Her/Hers)
Communications Director, Vermont
Planned Parenthood of Northern New England

784 Hercules Drive, Suite 110
Colchester, Vermont 05446
O: 802-448-9714 | C: 646-467-0674
www.ppnne.org | Eileen.Sullivan@ppnne.org

From: Clark, Charity [mailto:Charity.Clark@vermont.gov]
Sent: Monday, July 16, 2018 1:01 PM
To: Sullivan, Eileen
Cc: Leriche, Lucy Rose
Subject: RE: Press conference at 11am on Wednesday, July 18th at Planned Parenthood

Thanks, Eileen. Sounds great. I will send out the media advisory now.

Please let me know if PPNNE would like to include a quote in our press release. My aim is to have the press release wrapped up by tomorrow afternoon. Our practice is to send out press releases immediately following press conferences, so this release won't go out until after the conference. But it would be nice to have it all lined up and ready to go!

Thank you,
Charity

From: Sullivan, Eileen <Eileen.Sullivan@ppnne.org>
Sent: Monday, July 16, 2018 12:39 PM
To: Clark, Charity <Charity.Clark@vermont.gov>
Cc: Leriche, Lucy Rose <Lucy.Leriche@ppnne.org>
Subject: Press conference at 11am on Wednesday, July 18th at Planned Parenthood

Hi Charity,

So nice speaking with you earlier!

For today's media advisory, can you please include Meagan Gallagher, CEO and President of Planned Parenthood of Northern New England, as the speaker in addition to Attorney General Donovan? She is confirmed. I'll keep you posted on whether or not we're able to secure a health care provider to speak as well.

So we're confirmed for 11am on Wednesday, July 18th at Planned Parenthood of Northern New England, 784 Hercules Drive, in Colchester. We can use our podium, and broadcast crews can clamp their microphones to it.

I hope this is helpful to you, and please let me know if you need any additional info at this time!

Many thanks,

Eileen

Eileen Sullivan (She/Her/Hers)
Communications Director, Vermont
Planned Parenthood of Northern New England
784 Hercules Drive, Suite 110
Colchester, Vermont 05446
O: 802-448-9714 | C: 646-467-0674
www.ppnne.org | Eileen.Sullivan@ppnne.org

This email and any files transmitted with it are confidential and intended solely for the use of the individual or entity to whom they are addressed. If you have received this email in error please notify the system manager. Please note that any views or opinions presented in this email are solely those of the author and do not necessarily represent those of the company. Finally, the recipient should check this email and any attachments for the presence of viruses. The company accepts no liability for any damage caused by any virus transmitted by this email.

From:	Clark, Charity
To:	Spottswood, Eleanor; Diamond, Joshua
Subject:	RE: Vermont Department of Health
Date:	Tuesday, July 17, 2018 1:58:00 PM

Josh,

Should we also reach out to Welch's office to give them a heads-up? Happy to do it, or you can if you prefer.

Charity

From: Spottswood, Eleanor
Sent: Monday, July 16, 2018 4:40 PM
To: Clark, Charity <Charity.Clark@vermont.gov>; Diamond, Joshua <Joshua.Diamond@vermont.gov>
Subject: Vermont Department of Health

Hi Josh and Charity,

It occurs to me that I need to talk to our Department of Health about our official comment letter, if not also the website / press conference. The Department is the actual Title X grant recipient, after all—Planned Parenthood is just the sole subgrantee. I believe there is at least one policy analyst over there who is actively working on this topic. Do you have any concerns about me looping her in on our various Title X actions? And, should we invite anyone from the Department to attend the conference?

Thanks,

Ella

Eleanor L.P. Spottswood
Assistant Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, Vermont 05609
802-828-3178
eleanor.spottswood@vermont.gov

From: Diamond, Joshua
To: Clark, Charity; Spottswood, Eleanor
Subject: RE: Vermont Department of Health
Date: Tuesday, July 17, 2018 2:08:08 PM

Already done.   Josh

Joshua R. Diamond, Deputy Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, Vermont 05609
802-828-3175
joshua.diamond@vermont.gov

PRIVILEGED & CONFIDENTIAL COMMUNICATION: This communication may contain information that is privileged, confidential, and exempt from disclosure under applicable law. DO NOT read, copy or disseminate this communication unless you are the intended addressee. If you are not the intended recipient (or have received this E-mail in error) please notify the sender immediately and destroy this E-mail. Vermont's lobbyist registration and disclosure law applies to certain communications with and activities directed at the Attorney General.   Prior to any interactions with the Office of the Vermont Attorney General, you are advised to review Title 2, sections 261-268 of the Vermont Statutes Annotated, as well as the Vermont Secretary of State's most recent compliance guide available at https://www.sec.state.vt.us/elections/lobbying.aspx.

From: Clark, Charity
Sent: Tuesday, July 17, 2018 1:59 PM
To: Spottswood, Eleanor <Eleanor.Spottswood@vermont.gov>; Diamond, Joshua <Joshua.Diamond@vermont.gov>
Subject: RE: Vermont Department of Health

Josh,

Should we also reach out to Welch's office to give them a heads-up? Happy to do it, or you can if you prefer.

Charity

From: Spottswood, Eleanor
Sent: Monday, July 16, 2018 4:40 PM
To: Clark, Charity <Charity.Clark@vermont.gov>; Diamond, Joshua <Joshua.Diamond@vermont.gov>
Subject: Vermont Department of Health

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Ella

Eleanor L.P. Spottswood
Assistant Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, Vermont 05609
802-828-3178
eleanor.spottswood@vermont.gov

From:	Clark, Charity
To:	Spottswood, Eleanor
Subject:	Title X Talking Points Short - CRC edits.docx
Date:	Tuesday, July 17, 2018 3:14:00 PM
Attachments:	Title X Talking Points Short - CRC edits.docx

A couple of ideas.

Title X talking points—short

Title X

- the nationwide program for reproductive health care for low-income people
- funds clinics that provide the following:
  - cancer screening (pap smears to test for cancer-causing HPV virus)
  - birth control
  - contraception education
  - testing for sexually transmitted diseases and HIV
  - Title X funds are <u>never</u> used for abortion services
- In Vermont, the only clinics funded by Title X are Planned Parenthood clinics
- There are 10 Title X clinics in Vermont

Department of Health and Human Services:

- Issued new regulations for distributing Title X funds
- Using the regulations as a pretext to defund Planned Parenthood

Regulations:

- Require any Title X clinic to be physically separate from any facility that provides abortion—this is impractical and costly and serves no medical purpose~~impossible to do and simultaneously protect the right to abortion~~
- Impose a "gag rule" on Title X providers, so that they cannot properly counsel or refer patients for abortions
- Imposes both of these requirements on any Title X clinic's referral providers, potentially impacting a huge proportion of the health care system
- Requires Title X clinics to ignore the CDC's recommended approach to birth control and instead offer "natural family planning methods" only

Commented [CC1]: Or something along these lines

Commented [CC2]: Am I overstating this?

Notice and comment:

- These regulations haven't gone into effect yet
- Before they do, they have to solicit public comment
- It's important that the federal government hear from people who are likely to be impacted by these regulations
- That's why I made the website
- Comment period ends July 31

From:	Spottswood, Eleanor
To:	Donovan, Thomas; Diamond, Joshua; Clark, Charity
Subject:	Title X talking points
Date:	Tuesday, July 17, 2018 4:34:33 PM
Attachments:	2018-07-17 Title X Talking Points Short.docx 2018-07-17 Title X talking points long.docx

---

TJ,

Here are long and short versions of talking points for tomorrow. Let me know if anything doesn't make sense. See you tomorrow at 9:30.

Ella

Eleanor L.P. Spottswood
Assistant Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, Vermont 05609
802-828-3178
eleanor.spottswood@vermont.gov

Title X talking points—short

Title X:
- The nationwide program for funding reproductive health care for low-income people
- Funds clinics that provide the following:
  - cancer screening (pap smears to test for cancer-causing HPV virus)
  - birth control
  - contraception education
  - testing for sexually transmitted diseases and HIV
  - Title X funds are <u>never</u> used for abortion services
- Effective—for example, teen pregnancy rates have been falling consistently since the 80s, in Vermont and nationwide
- In Vermont, the only clinics funded by Title X are Planned Parenthood clinics
- There are 10 Title X clinics in Vermont

Department of Health and Human Services:
- Issued new regulations for distributing Title X funds
- Using the regulations as a pretext to defund Planned Parenthood

Regulations:
- Require any Title X clinic to be physically separate from any facility that provides abortion—this is impractical and costly and serves no medical purpose
- Impose a "gag rule" on Title X providers, so that they cannot properly counsel or refer patients for abortions
- Impose both of these requirements on any Title X clinic's referral providers, potentially impacting a huge proportion of the health care system
- Ignore the CDC's recommended approach to birth control and instead only require Title X clinics to offer "natural family planning methods"

Planned Parenthood in Vermont:
- Receives 40% of its operating budget from Title X
- PP's patients in Vermont are mostly poor, young, and uninsured
- Will be ineligible to receive Title X funding if these rules go into effect

Notice and comment:
- These regulations haven't gone into effect yet
- Before they do, they have to solicit public comment
- It's important that the federal government hear from people who are likely to be impacted by these regulations
- That's why I made the website
- Comment period ends July 31

Title X talking points—long

- Title X funds are used for reproductive healthcare:
    - cancer screening (pap smears to test for cancer-causing HPV virus)
    - birth control
    - contraception education
    - testing for sexually transmitted diseases and HIV
    - Title X funds are <u>never</u> used for abortion services
- Title X funding works
    - In Vermont and nationwide, teen pregnancies have fallen consistently during the decades that Title X has been in effect
        - In 1988, 81 out of 1000 teen women (ages 15-19) were pregnant in Vermont; in 2013, it was 28/1000
    - In Vermont and nationwide, abortion rates have also fallen steadily
        - In 1988, 38/1000 teen women (ages 15-19) had an abortion in Vermont; in 2013, it was 9/1000
- The Federal Department of Health and Human Services has issued new regulations for distributing Title X funding
    - It's using the new regulations as a pretext to abolish Planned Parenthood
    - Planned Parenthood is a leading provider of Title X services nationwide
- In Vermont, Planned Parenthood is the only Title X provider
    - Planned Parenthood receives 40% of its operating budget from Title X
    - Planned Parenthood's patients in Vermont are poor, young, and uninsured
        - 47% are low income (at or below the federal poverty line - $12,140/yr for an individual)
        - 24% are uninsured
        - 21% are under age 20
        - 8,719 Vermonters get care at Planned Parenthood annually: 7,796 women and 923 men
    - Planned Parenthood will be ineligible to receive Title X funding if these rules go into effect
- The rule requires onerous, costly, and medically inappropriate changes to Title X clinics
    - Physical and financial separation requirements mean opening separate clinics, in separate locations, with separate staff (and even separate email addresses) in order to provide abortion care
        - Economically unfeasible—no one provides so many abortions that it makes financial sense to do this, especially in Vermont
        - Stigmatizing for patients
        - Abortion-only clinics would be clear targets for political and physical attack
    - Separate medical records and lack of referrals mean no ability to coordinate care, which means worse outcomes for patients
- The new rules are illegal, as well as unhealthy and unethical
    - According to federal law (the Consolidated Appropriations Act), all pregnancy counseling funded by Title X must be "nondirective." This means that the patient must be provided with neutral information about all her options.
        - The new Title X regulations are not nondirective. They force clinicians to provide biased and misleading information to patients.
- The new Title X regulations redefine "family planning": they eliminate the requirement of providing "medically approved" methods of contraception
    - Instead, the new regulations emphasize "natural family planning methods"
    - The only family planning methods that Title X clinics will be required to provide are natural family planning methods
    - The new regulations eliminate all references to the CDC's quality family planning guidelines

- The regulations are ambitious:
  - They are designed to apply not just to Title X clinics, but also to any provider that gets regular referrals from a Title X clinic
  - The new regulations also prioritize funding Title X clinics that make a lot of referrals to comprehensive primary care providers
    - So, the new regulations are designed to apply to health care providers that don't even get Title X funding

- The regulations are political
  - Announced at the (anti-abortion group) Susan B. Anthony List's annual gala
  - Not based on evidence or medical need

- Notice and comment process
  - The federal government is taking comments on these regulations until July 31
  - It's important for the government to hear from:
    - people who have personal experiences with Title X clinics
    - people whose lives are impacted by these new regulations, including patients and health care providers
    - people of faith who support comprehensive, evidence-based health care
  - The government has to respond in some way to all the comments it receives

- Restrictions on abortion: parental notification
  - I trust Vermont women and Vermont doctors to make the choices that are best for each woman individually
    - That includes decisions about birth control, decisions about abortions, and decisions about who needs to know about those decisions
    - Sadly, there will be cases where parents will not be in a position to act in the best interests of their daughter, including in cases of incest and abuse
    - There is no one-size-fits-all answer to parental notification
    - That's why I believe that these are decisions that are best handled at the individual level, exactly the way they are today in Vermont

From:	Sullivan, Eileen
To:	Clark, Charity
Cc:	Wemple, Doug
Subject:	RE: Press release quote
Date:	Tuesday, July 17, 2018 4:52:32 PM

Will do! Many thanks to both of you!

Charity – I look forward to meeting you tomorrow! My cell is 646-467-0674.

Eileen

Eileen Sullivan (She/Her/Hers)
Communications Director, Vermont
Planned Parenthood of Northern New England
784 Hercules Drive, Suite 110
Colchester, Vermont 05446
O: 802-448-9714 | C: 646-467-0674
www.ppnne.org | Eileen.Sullivan@ppnne.org

From: Clark, Charity [mailto:Charity.Clark@vermont.gov]
Sent: Tuesday, July 17, 2018 4:16 PM
To: Sullivan, Eileen
Cc: Wemple, Doug
Subject: Press release quote

Hi, Eileen,

Once you have the approved quote for the press release, please email it to my assistant, Doug Wemple, and me. Doug will be making the final edits to our press release and can include the quote once it's ready.

See you tomorrow!
Charity
P.S. My cell phone if you need it tomorrow: 802-917-1993.

Charity R. Clark
Chief of Staff
Office of the Attorney General
109 State St.
Montpelier, Vermont 05609
802-828-3737

From:	Diamond, Joshua
To:	Clark, Charity
Subject:	RE: Draft press release on Title X
Date:	Wednesday, July 18, 2018 6:49:43 AM

Charity,

Overall, this looks good. I noticed there is no mention of planned parenthood. Should we be stating that PP is the only recipient of Title X funding in Vermont and this appears to be an assault upon this important provider of women's health care/reproductive health care?

Best, Josh

Joshua R. Diamond, Deputy Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, Vermont 05609
802-828-3175
joshua.diamond@vermont.gov

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From: Clark, Charity
Sent: Tuesday, July 17, 2018 11:27 AM
To: Donovan, Thomas <Thomas.Donovan@vermont.gov>; Diamond, Joshua <Joshua.Diamond@vermont.gov>; ella.spotswood@vermont.gov
Subject: Draft press release on Title X

Hi, all,

Here is the draft press release for tomorrow's conference on Title X. Please let me know if you have any edits. Note that we are still waiting for PPNNE's quote. T.J., please let me know if you approve your quotes: "Title X clinics provide essential health care to low-income Vermonters," Attorney General Donovan said. "These new rules are based on politics, not health care.

That's why I've created a website for Vermonters to tell HHS that these rules are bad for Vermont." And "It's important that the federal government hear from people whose lives will be affected by these rule changes. And, it's important that the federal government hear from people who support evidence-based health care," Donovan said.

STATE OF VERMONT
OFFICE OF THE ATTORNEY GENERAL
109 STATE STREET
MONTPELIER, VT 05609-1001

FOR IMMEDIATE RELEASE:
July 18, 2018

CONTACT: Ella Spottswood
Assistant Attorney General
802-828-3178

AG DONOVAN REQUESTS PUBLIC FEEDBACK ON RULE CHANGE AFFECTING WOMEN'S AND REPRODUCTIVE HEALTHCARE

Reproductive Health Clinics Jeopardized By Proposed Federal Regulations

MONTPELIER – Attorney General T.J. Donovan today announced the launch of a website to allow Vermonters to provide feedback on a proposed rule affecting clinics that receive Title X funds. The U.S. Department of Health and Human Services (HHS) is writing new rules for recipients of Title X. Title X is the only nationwide program for affordable birth control and reproductive health care. The proposed rules would implement a "gag rule" on abortion referrals and redirect clinicians from the CDC's birth control recommendations to "natural family planning methods." HHS is accepting public comments on the new rules until July 31. The AG's website where the public can provide feedback is located at: http://ago.vermont.gov/act_now_for_womens_health/.

"Title X clinics provide essential health care to low-income Vermonters," Attorney General Donovan said. "These new rules are based on politics, not health care. That's why I've created a website for Vermonters to tell HHS that these rules are bad for Vermont."

Vermont has relied on funding from Title X for decades. Title X funds basic health care services, including wellness exams, cervical and breast cancer screenings, birth control, contraception education, and testing for sexually transmitted diseases and HIV. As a result of the new regulations, however, Title X providers will be forced to give incomplete and misleading information to patients—a "gag rule" on providing services or information related to abortion, even to patients who affirmatively say that they want one. But the rules don't stop there. The gag rule would also apply to any "referral partners" of Title X clinics. And, the new rules stretch Title X funding to try to cover gap in health care created by employers who opt out of providing insurance to cover contraception. The new rules also redefine "family planning" itself to promote "natural family planning methods" over more effective forms of birth control. The new rules never mention the CDC's evidence-based best practices guidelines, "Providing Quality Family Planning Services," which was the gold standard for health care under the old Title X regulations. Title X funding is not used for abortions. In addition, the new rules require Title X clinic to be physically located in a separate facility from any abortion provider.

Vermont has ten clinics supported by Title X funds, located in Barre, Bennington, Brattleboro, Hyde Park, Rutland, Middlebury, Newport, St. Albans, St. Johnsbury, and White River Junction. All provide crucial basic health care to underserved populations. Funding for each of these clinics is jeopardized by the new rules.

"It's important that the federal government hear from people whose lives will be affected by these rule changes. And, it's important that the federal government hear from people who support evidence-based health care," Donovan said.

[PPNNE quote]

Vermonters who are concerned about the impact of these regulations can get more information and submit comments through a website set up by the Attorney General's Office: http://ago.vermont.gov/act_now_for_womens_health/

More information about the changes to Title X can be found at the independent

Guttmacher Institute: https://www.guttmacher.org/article/2018/06/domestic-gag-rule-and-more-administrations-proposed-changes-title-x

Charity R. Clark
Chief of Staff
Office of the Attorney General
109 State St.
Montpelier, Vermont 05609
802-828-3737

From:	Wemple, Doug
To:	Sullivan, Eileen; Clark, Charity
Subject:	RE: Press release quote
Date:	Wednesday, July 18, 2018 9:30:30 AM

Hi Eileen!

Thank you for sending this along, I will add it to our press release now. I defer to Charity regarding RSVP's from the media for today's press conference.

Please let me know if you have any questions in the meantime.

Sincerely,

Doug Wemple

Doug Wemple
Executive Assistant
Vermont Attorney General's Office
109 State Street - Montpelier, VT
Office: (802)828-5515

From: Sullivan, Eileen [mailto:Eileen.Sullivan@ppnne.org]
Sent: Wednesday, July 18, 2018 9:29 AM
To: Clark, Charity <Charity.Clark@vermont.gov>
Cc: Wemple, Doug <Doug.Wemple@partner.vermont.gov>
Subject: RE: Press release quote

Good morning, Charity and Doug!

Below is the quote for today's press release. Many thanks for your patience! Do you have any RSVP's from media for this morning?

"For decades, people in Vermont have benefited from affordable reproductive health care through Title X, and new rule changes from the Trump administration threaten to take that away," said Meagan Gallagher, CEO and President of Planned Parenthood of Northern New England. "We are incredibly grateful to Attorney General Donovan for his ongoing support for access to high-quality health care for all Vermonters, and for creating a new avenue for people to tell the administration they won't stand for attacks on access to reproductive health care."

Many thanks for everything!

Eileen

Eileen Sullivan (She/Her/Hers)

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From: Clark, Charity [mailto:Charity.Clark@vermont.gov]
Sent: Tuesday, July 17, 2018 4:16 PM
To: Sullivan, Eileen
Cc: Wemple, Doug
Subject: Press release quote

Hi, Eileen,

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See you tomorrow!
Charity
P.S. My cell phone if you need it tomorrow: 802-917-1993.

Charity R. Clark
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Office of the Attorney General
109 State St.
Montpelier, Vermont 05609
802-828-3737

From:	Sullivan, Eileen
To:	Clark, Charity
Cc:	Wemple, Doug
Subject:	RE: Press release quote
Date:	Wednesday, July 18, 2018 9:32:50 AM

Good morning, Charity and Doug!

Below is the quote for today's press release. Many thanks for your patience! Do you have any RSVP's from media for this morning?

"For decades, people in Vermont have benefited from affordable reproductive health care through Title X, and new rule changes from the Trump administration threaten to take that away," said Meagan Gallagher, CEO and President of Planned Parenthood of Northern New England. "We are incredibly grateful to Attorney General Donovan for his ongoing support for access to high-quality health care for all Vermonters, and for creating a new avenue for people to tell the administration they won't stand for attacks on access to reproductive health care."

Many thanks for everything!

Eileen

Eileen Sullivan (She/Her/Hers)
Communications Director, Vermont
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Charity R. Clark
Chief of Staff
Office of the Attorney General
109 State St.
Montpelier, Vermont 05609
802-828-3737

From:	Sullivan, Eileen
To:	Wemple, Doug; Clark, Charity
Subject:	RE: Press release quote
Date:	Wednesday, July 18, 2018 9:39:35 AM

Thank you, Doug!

Eileen

Eileen Sullivan (She/Her/Hers)
Communications Director, Vermont
Planned Parenthood of Northern New England
784 Hercules Drive, Suite 110
Colchester, Vermont 05446
O: 802-448-9714 | C: 646-467-0674
www.ppnne.org | Eileen.Sullivan@ppnne.org

From: Wemple, Doug [mailto:Doug.Wemple@partner.vermont.gov]
Sent: Wednesday, July 18, 2018 9:30 AM
To: Sullivan, Eileen; Clark, Charity
Subject: RE: Press release quote

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Doug Wemple

Doug Wemple
Executive Assistant
Vermont Attorney General's Office
109 State Street - Montpelier, VT
Office: (802)828-5515

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Sent: Wednesday, July 18, 2018 9:29 AM
To: Clark, Charity <Charity.Clark@vermont.gov>
Cc: Wemple, Doug <Doug.Wemple@partner.vermont.gov>
Subject: RE: Press release quote

Good morning, Charity and Doug!

Below is the quote for today's press release. Many thanks for your patience! Do you have any RSVP's from media for this morning?

"For decades, people in Vermont have benefited from affordable reproductive health care through Title X, and new rule changes from the Trump administration threaten to take that away," said Meagan Gallagher, CEO and President of Planned Parenthood of Northern New England. "We are incredibly grateful to Attorney General Donovan for his ongoing support for access to high-quality health care for all Vermonters, and for creating a new avenue for people to tell the administration they won't stand for attacks on access to reproductive health care."

Many thanks for everything!

Eileen

Eileen Sullivan (She/Her/Hers)
Communications Director, Vermont
Planned Parenthood of Northern New England
784 Hercules Drive, Suite 110
Colchester, Vermont 05446
O: 802-448-9714 | C: 646-467-0674
www.ppnne.org | Eileen.Sullivan@ppnne.org

From: Clark, Charity [mailto:Charity.Clark@vermont.gov]
Sent: Tuesday, July 17, 2018 4:16 PM
To: Sullivan, Eileen
Cc: Wemple, Doug
Subject: Press release quote

Hi, Eileen,

Once you have the approved quote for the press release, please email it to my assistant, Doug Wemple, and me. Doug will be making the final edits to our press release and can include the quote once it's ready.

See you tomorrow!
Charity
P.S. My cell phone if you need it tomorrow: 802-917-1993.

Charity R. Clark
Chief of Staff
Office of the Attorney General
109 State St.
Montpelier, Vermont 05609

802-828-3737

From: Clark, Charity
To: Diamond, Joshua
Subject: Re: Draft press release on Title X
Date: Wednesday, July 18, 2018 9:41:07 AM

It's a good point. After their quote we can add a sentence.

Charity

Sent from my iPhone

On Jul 18, 2018, at 6:49 AM, Diamond, Joshua <Joshua.Diamond@vermont.gov> wrote:

> Charity,
>
> Overall, this looks good. I noticed there is no mention of planned parenthood. Should we be stating that PP is the only recipient of Title X funding in Vermont and this appears to be an assault upon this important provider of women's health care/reproductive health care?
>
> Best, Josh
>
> Joshua R. Diamond, Deputy Attorney General
> Vermont Attorney General's Office
> 109 State Street
> Montpelier, Vermont 05609
> 802-828-3175
> joshua.diamond@vermont.gov
>
> PRIVILEGED & CONFIDENTIAL COMMUNICATION: This communication may contain information that is privileged, confidential, and exempt from disclosure under applicable law. DO NOT read, copy or disseminate this communication unless you are the intended addressee. If you are not the intended recipient (or have received this E-mail in error) please notify the sender immediately and destroy this E-mail. Vermont's lobbyist registration and disclosure law applies to certain communications with and activities directed at the Attorney General. Prior to any interactions with the Office of the Vermont Attorney General, you are advised to review Title 2, sections 261-268 of the Vermont Statutes Annotated, as well as the Vermont Secretary of State's most recent compliance guide available at https://www.sec.state.vt.us/elections/lobbying.aspx.
>
> ---
>
> **From:** Clark, Charity
> **Sent:** Tuesday, July 17, 2018 11:27 AM
> **To:** Donovan, Thomas <Thomas.Donovan@vermont.gov>; Diamond, Joshua

<Joshua.Diamond@vermont.gov>; ella.spotswood@vermont.gov
Subject: Draft press release on Title X

Hi, all,

Here is the draft press release for tomorrow's conference on Title X. Please let me know if you have any edits. Note that we are still waiting for PPNNE's quote. T.J., please let me know if you approve your quotes: "Title X clinics provide essential health care to low-income Vermonters," Attorney General Donovan said. "These new rules are based on politics, not health care. That's why I've created a website for Vermonters to tell HHS that these rules are bad for Vermont." And "It's important that the federal government hear from people whose lives will be affected by these rule changes. And, it's important that the federal government hear from people who support evidence-based health care," Donovan said.

STATE OF VERMONT
OFFICE OF THE ATTORNEY GENERAL
109 STATE STREET
MONTPELIER, VT 05609-1001

FOR IMMEDIATE RELEASE: CONTACT: Ella
Spottswood
July 18, 2018 Assistant
Attorney General
802-828-3178

AG DONOVAN REQUESTS PUBLIC FEEDBACK ON RULE CHANGE AFFECTING WOMEN'S AND REPRODUCTIVE HEALTHCARE

Reproductive Health Clinics Jeopardized By Proposed Federal Regulations

MONTPELIER – Attorney General T.J. Donovan today announced the launch of a website to allow Vermonters to provide feedback on a proposed rule affecting clinics that receive Title X funds. The U.S. Department of Health and Human Services (HHS) is writing new rules for recipients of Title X. Title X is the only

nationwide program for affordable birth control and reproductive health care. The proposed rules would implement a "gag rule" on abortion referrals and redirect clinicians from the CDC's birth control recommendations to "natural family planning methods." HHS is accepting public comments on the new rules until July 31. The AG's website where the public can provide feedback is located at: http://ago.vermont.gov/act_now_for_womens_health/.

"Title X clinics provide essential health care to low-income Vermonters," Attorney General Donovan said. "These new rules are based on politics, not health care. That's why I've created a website for Vermonters to tell HHS that these rules are bad for Vermont."

Vermont has relied on funding from Title X for decades. Title X funds basic health care services, including wellness exams, cervical and breast cancer screenings, birth control, contraception education, and testing for sexually transmitted diseases and HIV. As a result of the new regulations, however, Title X providers will be forced to give incomplete and misleading information to patients —a "gag rule" on providing services or information related to abortion, even to patients who affirmatively say that they want one. But the rules don't stop there. The gag rule would also apply to any "referral partners" of Title X clinics. And, the new rules stretch Title X funding to try to cover gap in health care created by employers who opt out of providing insurance to cover contraception. The new rules also redefine "family planning" itself to promote "natural family planning methods" over more effective forms of birth control. The new rules never mention the CDC's evidence-based best practices guidelines, "Providing Quality Family Planning Services," which was the gold standard for health care under the old Title X regulations. Title X funding is not used for abortions. In addition, the new rules require Title X clinic to be physically located in a separate facility from any abortion provider.

Vermont has ten clinics supported by Title X funds, located in Barre, Bennington, Brattleboro, Hyde Park, Rutland, Middlebury, Newport, St. Albans, St. Johnsbury, and White River Junction. All provide crucial basic health care to underserved populations. Funding for each of these clinics is jeopardized by the new rules.

"It's important that the federal government hear from people whose lives will be affected by these rule changes. And, it's important that the federal government hear from people who support evidence-based health care," Donovan said.

[PPNNE quote]

Vermonters who are concerned about the impact of these regulations can get more information and submit comments through a website set up by the Attorney General's Office: http://ago.vermont.gov/act_now_for_womens_health/

More information about the changes to Title X can be found at the independent Guttmacher Institute: https://www.guttmacher.org/article/2018/06/domestic-gag-rule-and-more-administrations-proposed-changes-title-x

Charity R. Clark
Chief of Staff
Office of the Attorney General
109 State St.
Montpelier, Vermont 05609
802-828-3737

From:	Wemple, Doug
To:	Donovan, Thomas; Diamond, Joshua; Clark, Charity; Spottswood, Eleanor
Subject:	Today"s Press Release w/PPNE Quote
Date:	Wednesday, July 18, 2018 9:45:57 AM
Attachments:	Title X Press Release 7.18.2018.pdf

Attached! Let me know if you have any questions or changes. Otherwise, it's ready to go once the conference is over.

Thanks!

Doug Wemple
Executive Assistant
Vermont Attorney General's Office
109 State Street - Montpelier, VT
Office: (802)828-5515

STATE OF VERMONT
OFFICE OF THE ATTORNEY GENERAL
109 STATE STREET
MONTPELIER, VT 05609-1001

FOR IMMEDIATE RELEASE: July 18, 2018

CONTACT: Eleanor Spottswood
Assistant Attorney General
802-828-3178

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# # #

From: Clark, Charity
To: Sullivan, Eileen
Cc: Wemple, Doug
Subject: Re: Press release quote
Date: Wednesday, July 18, 2018 9:48:21 AM

Doug, after the quote, please add the sentence: Planned Parenthood is the only recipient of Title X funds in Vermont. (Eileen, is that an appropriate characterization, or is the "recipient" technically the Vermont Department of Health, and we should use a different term to describe PP, like "beneficiary"? I prefer "recipient" so I hope that's good.)

Eileen, we have made follow-up calls to all TV stations and reporters who have written in this topic in the past. We know some are coming.

See you soon!
Charity

Sent from my iPhone

On Jul 17, 2018, at 4:52 PM, Sullivan, Eileen <Eileen.Sullivan@ppnne.org> wrote:

> Will do! Many thanks to both of you!
>
> Charity – I look forward to meeting you tomorrow! My cell is 646-467-0674.
>
> Eileen
>
> **Eileen Sullivan (She/Her/Hers)**
> Communications Director, Vermont
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> 784 Hercules Drive, Suite 110
> Colchester, Vermont 05446
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> www.ppnne.org | Eileen.Sullivan@ppnne.org
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> ---
>
> **From:** Clark, Charity [mailto:Charity.Clark@vermont.gov]
> **Sent:** Tuesday, July 17, 2018 4:16 PM
> **To:** Sullivan, Eileen
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> **Subject:** Press release quote
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Chief of Staff
Office of the Attorney General
109 State St.
Montpelier, Vermont 05609
802-828-3737

From: Sullivan, Eileen
To: Clark, Charity
Cc: Wemple, Doug
Subject: RE: Press release quote
Date: Wednesday, July 18, 2018 9:59:03 AM

We cover all bases by saying, “Planned Parenthood of Northern New England is the only Title X provider in Vermont.”

Thank you for the media update, and we’ll see you soon!

Eileen

Eileen Sullivan (She/Her/Hers)
Communications Director, Vermont
Planned Parenthood of Northern New England
784 Hercules Drive, Suite 110
Colchester, Vermont 05446
O: 802-448-9714 | C: 646-467-0674
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Sent: Wednesday, July 18, 2018 9:48 AM
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802-828-3737

From: Wemple, Doug
To: Sullivan, Eileen; Clark, Charity
Subject: RE: Press release quote
Date: Wednesday, July 18, 2018 9:59:39 AM

Thank you! I will add now

Doug Wemple
Executive Assistant
Vermont Attorney General's Office
109 State Street - Montpelier, VT
Office: (802)828-5515

From: Sullivan, Eileen [mailto:Eileen.Sullivan@ppnne.org]
Sent: Wednesday, July 18, 2018 9:59 AM
To: Clark, Charity <Charity.Clark@vermont.gov>
Cc: Wemple, Doug <Doug.Wemple@partner.vermont.gov>
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> Montpelier, Vermont 05609
> 802-828-3737

From: Clark, Charity
To: Wemple, Doug
Cc: Sullivan, Eileen
Subject: Re: Press release quote
Date: Wednesday, July 18, 2018 10:03:05 AM

Great. Thanks, Doug!

Sent from my iPhone

On Jul 18, 2018, at 9:59 AM, Wemple, Doug <Doug.Wemple@partner.vermont.gov> wrote:

> Thank you! I will add now
>
> **Doug Wemple**
> Executive Assistant
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> 109 State Street - Montpelier, VT
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>
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FOR IMMEDIATE RELEASE:
July 18, 2018

CONTACT: Eleanor Spottswood
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