

October 2, 2026

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C., 20510

Re: Request for Information on Health Coverage That Works for Everyone

Dear Senator Wyden:

The [Medicaid and Reproductive Justice \(RJ\) Collaborative](#) (Collaborative) appreciates the opportunity to respond to the Senate Finance Committee's (Committee) [Request for Information](#) (RFI) on "Health Care That Works for Everyone." The Collaborative works to advance the RJ movement's vision for Medicaid and universal health care reform. It is directed by a Leadership Council composed of [In Our Own Voice: National Black Women's Reproductive Justice Agenda](#), the [National Asian Pacific American Women's Forum](#), the [National Latina Institute for Reproductive Justice](#), and [Unite for Reproductive & Gender Equity](#) and anchored by the [National Health Law Program](#). Our members include over 30 RJ organizations representing every U.S. region, as well as unaffiliated RJ activists. Rather than responding to each individual topic contained in the RFI, the Collaborative and our undersigned allies are submitting our enclosed [Reproductive Justice Principles for Federal Universal Health Care Reform](#) (*Principles*), which speak directly to those topics.

RJ is a framework developed by Black women that recognizes that reproductive autonomy depends on more than just reproductive rights. It encompasses the human rights to bodily autonomy and to have children, not have children, and to parent in safe and healthy communities with dignity and support. It recognizes that exercising these rights requires the economic, social, and political resources necessary to make meaningful decisions about one's body, health, family, and future. At a time when the anti-abortion movement is trying to redefine the idea of "family values," the RJ framework is necessary to guide us toward a future that is truly supportive of families.

Reproductive oppression — the systemic control and exploitation of people's bodies, sexuality, labor, and reproductive lives by individuals, institutions, and society — is the opposing force to RJ. It is a form of structural violence rooted in intersecting systems of white supremacy, cisheteropatriarchy, capitalism, colonialism, and ableism. Reproductive oppression has long shaped the U.S. health care system and the policies and practices that determine who can access care, what kinds of care are covered, and whose health and autonomy are valued. The [Medicaid program](#), for example, has simultaneously allowed millions to access care, while

perpetuating exclusionary policies such as immigrant eligibility restrictions, the Hyde Amendment, and more recently, limitations on gender-affirming care. Recent historic cuts to Medicaid represent a significant iteration of these barriers, but they build on longstanding policy.

The RJ movement has raised concerns about these health policy choices for decades. In 1994, twelve Black women gathered to discuss the Clinton administration's health care reform plan, which failed to address the unique struggles and voices of Black women and other underserved groups. Their resulting letter to Congress, [Black Women on Health Care Reform](#), called for universal, comprehensive health coverage, equitable access to the full range of health services, including abortion, strong nondiscrimination protections, and meaningful representation of Black women in health care decision-making. These arguments were echoed by RJ advocates in subsequent health care reform efforts, including the Affordable Care Act (ACA). While the ACA expanded health coverage to millions, it also [excluded millions of immigrants](#) and [prohibited federal funding for abortion coverage](#) under Marketplace plans. RJ advocates have continued to identify gaps in the law and called for a health care system that more fully addresses the needs of communities underserved by the health care system.

To foster health coverage that works for everyone, reform cannot reproduce the same inequities that have characterized health policy for generations. To that end, in 2024, the Collaborative published our *Principles*. Expanding upon the foundation laid by *Black Women on Health Care Reform*, our *Principles* provide an actionable framework for the design and evaluation of federal health care reform proposals and address many topics in the RFI:

- We appreciate Ranking Member Wyden and his colleagues' intention to reverse [H.R. 1](#)'s Medicaid and ACA cuts. The law's cuts to eligibility, enrollment, and financing mechanisms are devastating for RJ and are wholly inconsistent with our *Principles*.
- The RFI requests feedback on "[r]eimagining a coverage system that provides all Americans with a Medicare-type choice regardless of income, job status, or ability to afford premiums" (p. 6). Our first principle calls for universal health coverage for all, regardless of immigration or citizenship status, income, employment status, disability, gender identity, sexual orientation, or other factors. Further, consistent with our fifth principle, any reimagined coverage system should not provide less coverage or consumer protections than Medicaid, which is often more robust than Medicare, but should also address longstanding gaps.
- The RFI asks about establishing and codifying standardized benefits, particularly in the Marketplace or under a public option. Consistent with our fifth principle, aligning benefits with RJ necessitates truly comprehensive coverage. This must include full-spectrum sexual, reproductive, and gender-affirming care without age restrictions, including abortion coverage, full-spectrum doula care, menstrual product, and menopause-related care. The *Principles* detail coverage needs across the full range of service areas.
- The RFI asks about cost-sharing. Consistent with our sixth principle, premiums, deductibles, and cost-sharing requirements prevent meaningful access to care and should not exist, particularly for people with low incomes.
- The RFI requests feedback on the enforcement of health rights and consumer-friendly enrollment. Consistent with our eighth principle, people must have uninterrupted access

to care and be able to enforce their rights. We offer specific parameters for such protections as well as public education and outreach.

- The RFI briefly discusses discriminatory benefit design (p. 46). We address the importance of expanding upon current nondiscrimination protections, such as § 1557 of the ACA, in our fourth principle.
- The RFI does not seek feedback on health care confidentiality. That said, we view this as a critical area for reform. Bodily autonomy is under attack, particularly in the contexts of abortion, contraception, and gender-affirming care, and particularly for minors. Medicaid data is being weaponized against immigrant communities. We are concerned that menstrual cycle-tracking apps could be used to criminalize those who experience pregnancy loss and/or have abortions. It is of the utmost importance that Congress strengthen patient privacy protections well beyond what the Health Insurance Portability and Accountability Act provides.
- Lastly, policymakers must listen to the communities most harmed by the current health care system, who have long articulated a more equitable vision. Consistent with our second principle, members of Congress who are Black, Indigenous, and People of Color, LGBTQI+ people, immigrants, disabled, and come from low-income families, and who live at these intersections, should have an equitable seat at the table for any health care reform efforts. Consistent with our third principle, underrecognized communities, and particularly people with lived experience with reproductive oppression, should have meaningful engagement opportunities at every stage of the health care reform process, from design to implementation and evaluation. The people closest to the problems are often closest to the solutions.

We are grateful to Ranking Member Wyden for his leadership in exploring how we can build a health care system that works for everyone. We appreciate your consideration of the enclosed *Principles* as a framework for designing and evaluating policy options to ensure that they promote, rather than undermine RJ. We welcome the opportunity to work with the Committee to address the issues and recommendations above. If you have any questions, please contact Sydelle Barreto (sbarreto@napawf.edu), Madeline Morcelle (morcelle@healthlaw.org), and Salen Andrews (sandrews@latinainstitute.org).

Sincerely,

National Organizations

Autistic Women & Nonbinary Network

Black Girls Vote

Black Women's Health Imperative

CARE Colorado

Center for Law and Social Policy (CLASP)

Center for Racial & Disability Justice (CRDJ)

Community Catalyst

Disability Rights Education and Defense Fund (DREDF)
Guttmacher Institute
Healthy Teen Network
Ibis Reproductive Health
Implementing Contraceptive Access Now (ICAN!)
In Our Own Voice: National Black Women's Reproductive Justice Agenda
Institute for Women's Policy Research
Jacobs Institute of Women's Health
Just Futures Collaborative
National Abortion Federation
National Asian Pacific American Women's Forum
National Family Planning & Reproductive Health Association
National Health Law Program
National Institute for Reproductive Health
National Latina Institute for Reproductive Justice
National Network of Abortion Funds
National Organization for Women
National Partnership for Women & Families
National Women's Law Center
Nicole Clark Consulting, LLC
Organization for Latino Health Advocacy
Physicians for Reproductive Health
Power to Decide
Prevention at the Intersections
Religious Community for Reproductive Choice
Reproductive Health Access Project
SIECUS: Sex Ed for Social Change
State Innovation Exchange Action
Transgender Law Center
URGE: Unite for Reproductive & Gender Equity

Local, State, and Regional Organizations & Individuals

New Disabled South, *Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia*
AccessBetter© Sexual And Reproductive Health Education, *California*

ACT for Women and Girls, *California*
Ariana Thompson-Lastad, PhD, *California*
California Women's Law Center, *California*
Equality California, *California*
Isabel Muñoz, *California*
Lynne Wittenberg, *California*
Lyon-Martin Community Health Services, *California*
TEACH - Training in Early Abortion for Comprehensive Healthcare, *California*
Leah Torres, MD MS, *Colorado*
Catherine Dentinger, *Georgia*
The Porchlight Collective SAP, *Illinois*
Beurre Roux, *Louisiana*
Heather Jackson, MA, MPH, CGS, LMHC, LCMHC, LPC, and LCPC, *Maryland, Massachusetts, New York, Rhode Island, Vermont, Virginia*
Naomi Gaspard, *Maryland*
Bonnie Gorman RN, MS, *Massachusetts*
Chrismery A Gonzalez, MPH, *Massachusetts*
Gina Arias, RN, MPH, *Massachusetts*
Kene Orakwue, *Massachusetts*
Michigan Chamber for Reproductive Justice, *Michigan*
Amy Hecht-Zizes, *Minnesota*
Montanans for Choice Take Action, *Montana*
Angelica Vega, *New Jersey*
Mariposa Fund, *New Mexico*
Laila Ruffin, *New York*
Mary Ann Castle, Ph.D., *New York*
Leah Morcelle, *North Carolina*
Trude Bennett, *North Carolina*
Abortion Forward, *Ohio*
Lucille Pilling, *Pennsylvania*
Susan Bell, *Pennsylvania*
Walter Tsou, *Pennsylvania*
Avow, *Texas*
Gabe Gordon
Liz Salomon

Reproductive Justice Principles for Federal Universal Health Care Reform

Thirty years ago, [twelve Black women](#) — Dr. Toni M. Bond Leonard, Reverend Alma Crawford, Evelyn S. Field, Terri James, Bisola Marignay, Cassandra McConnell, Cynthia Newbille, Loretta Ross, Elizabeth Terry, 'Able' Mable Thomas, Winnette P. Willis, and Kim Youngblood—gathered to discuss the Clinton administration's health care reform plan, which, similar to the white-led pro-choice and mainstream feminist movements, failed to address the unique struggles and voices of Black women and other marginalized groups. On August 16, 1994, the group, called Women of African Descent for Reproductive Justice, published a [full-page letter to Congress](#) in the *Washington Post* and *Roll Call* titled "Black Women on Health Care Reform." They demanded universal, comprehensive, and affordable health coverage and access with robust nondiscrimination protections for all. They expressed the urgent need for equitable access to all health services, including diagnostic, treatment, preventive, long-term care, mental health services, prescription drugs, and care for people with pre-existing conditions. They would "not endorse a health care reform system that does not cover the full range of reproductive services for all women—including abortion." They emphasized that the U.S. would not achieve these goals until Black women had meaningful representation in national, state, and local planning, review, and decision-making bodies. Nearly 850 Black women signed on.

Through that action, they forged a groundbreaking analytical, organizing, and movement-building framework rooted in intersectionality, human rights, and social justice. [Reproductive justice](#) (RJ) is the human right to bodily autonomy; to have children, not have children, and raise them in safe, healthy, and sustainable communities; and to live with dignity. Ultimately, RJ can only be achieved [when all people have](#) the economic, social, and political power and resources to make their own decisions about their bodies, health, sexuality, families, and reproduction.

While some progress has been made to advance RJ in health care, significant challenges remain. For example, Medicaid eligibility gaps in [non-expansion states](#) and for [many immigrants](#) persist. The last several years have marked backsliding in the fight for RJ in health care. In 2022, the Supreme Court of the United States ushered in another setback when it overturned the constitutional right to abortion in *Dobbs v. Jackson Women's Health Organization*. While that right was never enough to ensure access, especially for underrecognized and low-income communities due to barriers such as the Hyde Amendment, *Dobbs* has made things much worse. Gender-affirming care and vital preventive services such as pre-exposure prophylaxis (PreP) for HIV and contraceptives are also facing intensified attacks.

The Medicaid and Reproductive Justice Collaborative is comprised of Advocates for Youth, In Our Own Voice: National Black Women's Reproductive Justice Agenda, National Asian Pacific American Women's Forum, the National Health Law Program, the National Latina Institute for Reproductive Justice, and Unite for Reproductive & Gender Equity. Together, we have developed the following *Reproductive Justice Principles for Federal Universal Health Care Reform (Principles)* for policymakers and advocates. In honor of the RJ movement's thirtieth anniversary, our *Principles* aim to build upon the vision articulated by the Women of African Descent for Reproductive Justice in their 1994 letter to Congress, addressing persistent reproductive injustices in our health care system today. The Medicaid and Reproductive Justice Collaborative calls on Congress to prioritize the following RJ *Principles* in federal universal health care reform efforts:

1. All people in the U.S. experience the human right to universal health care coverage and access, including access to culturally and linguistically appropriate sexual, reproductive, and gender-affirming health care.

Universal health care coverage means that everyone living in any U.S. state or territory should have access to health coverage and care that reflects the principles below, regardless of race, ethnicity, sex (including sex stereotypes, pregnancy or related conditions, sex characteristics including intersex traits, gender identity, sexual orientation, and sexual activity or behavior), national origin, immigration status or length of stay, migrant status, language, disability, age, income (including source of income or use of public benefits), fatphobia, or any combination thereof. This human right encompasses a comprehensive range of services necessary to support physical, mental, and social well-being. Under the international human rights framework, this unequivocally includes ensuring access to culturally and linguistically appropriate sexual, reproductive, and gender-affirming health care. By firmly establishing health care as a fundamental human right within the framework of RJ, we resolutely affirm the intrinsic dignity and worth of every individual.

2. Underrecognized communities are equitably represented among policymakers.

Equitable representation at every level of health care, including policymaking, is essential to ensure that universal health care reform truly serves all communities, particularly those that have historically been marginalized and underrecognized. These communities must have equitable access to all institutions that hold power over people's health care. To achieve RJ in our health care system, we cannot entrust decisions solely to the communities that have benefited from longstanding systems of domination and oppression. We must invest in the leadership of policymakers and candidates from underrecognized communities in federal health policymaking bodies, such as Congress, the White House, and the U.S. Department of Health and Human Services. This includes Black, Latine, Indigenous, Asian American, Pacific Islander, and other people of color; Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Plus (LGBTQI+ people), im/migrants, people with limited English proficiency (LEP), disabled people, youth, individuals with lower socioeconomic status, and those who live at the intersections of multiple marginalized identities. We believe that lived experience with systemic inequities can provide invaluable insights and unique perspectives, as we recognize that the people closest to the problems are often closest to the solutions. Achieving participatory parity will help ensure that universal health care reform is grounded in the realities and needs of diverse communities, ensuring that their perspectives, concerns, and expertise are genuinely considered and integrated into policy discussions and decision-making and resulting in a more inclusive and responsive policymaking process.

3. Underrecognized communities' concerns and vision guide reform throughout design, implementation, and evaluation.

Meaningful community engagement at every stage of the universal health care reform process (e.g., design, implementation, evaluation, iteration) is crucial to ensure that we are working toward a more inclusive, effective, and equitable health care system that fosters RJ for all. Policymakers must prioritize centering the expertise and addressing the concerns of communities most impacted by systemic reproductive oppression, beginning with centering and deeply listening to underrecognized communities.

4. All people are liberated from health care discrimination.

Achieving RJ requires liberation from discrimination or coercion. Historically and presently, underrecognized communities have faced heightened discrimination, bias, and neglect within our health care system. Reform must build and expand upon current nondiscrimination protections, such as those outlined in [Section 1557 of the Affordable Care Act](#) (ACA). This includes strengthening protections against discrimination by health care entities and professionals (e.g., all health insurance plans, all health-care providers and professionals, and all government agencies), including reproductive coercion and barriers to culturally and linguistically congruent care, based on race, ethnicity, sex (including sex stereotypes, pregnancy or related conditions including abortion, sex characteristics such as intersex traits, gender identity, sexual orientation, sexual activity or behavior), national origin, immigration status or length of stay, language, disability, age, income (including source of income and public benefits), fatphobia, or any combination thereof. Examples of discriminatory practices include, but are not limited to, reproductive coercion such as forced or coercive sterilization or other forms of contraception, barriers to contraception and abortion access, obstetric violence, inadequate pain management, and denials of culturally and linguistically congruent care based on any of the classes listed above. Equitable access necessitates halting these discriminatory practices and ensuring meaningful participation in health care programs and services for historically marginalized communities. Addressing these inequities demands targeted education and accountability for health care providers to enhance standards of care and eliminate bias.

5. Coverage includes comprehensive benefits that meet all health care needs.

Universal health care reform must ensure access to the health care needs of all people living in the United States. Centering RJ in reform means eliminating benefit coverage gaps and providing coverage without any annual or lifetime limits. The current Medicaid program provides a current baseline to serving individuals with low-incomes and their unique needs. Thus, universal health care reform must ensure that those currently eligible for Medicaid and future enrollees with low incomes receive, at a minimum, the services they would receive through Medicaid. To achieve the principles of RJ, federal universal health care must include:

- **Sexual, Reproductive, and Gender-Affirming Care Services:** Coverage must include full-spectrum sexual, reproductive, and gender-affirming health care, adhering to medical standards of care. Benefit packages must at least cover: abortion services; preventive services as currently recognized by the ACA (e.g., contraception; STI and HIV preventive services such as PreP); full-spectrum doula services; pregnancy care (e.g., midwifery care(including registered and community midwives); pelvic floor therapy); unbiased and medically accurate counseling; care for chronic sexual and reproductive health conditions (e.g., viral load suppression for HIV); menstrual products; and gender-affirming care.

-
- **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services:** Enrollees under age 21 must be eligible to receive Early and Periodic Screening, Diagnostic, and Treatment coverage at least as required currently under the Medicaid Act. This includes timely and appropriate medical screenings to detect, treat, or manage potential conditions. Medical screenings must be comprehensive and include: vision, dental, hearing, and medical services (e.g., physical examination, immunization, laboratory testing, developmental history, and health education, including comprehensive and gender-affirming sexuality education). After screenings, providers must arrange for treatment of conditions.
 - **Mental Health and Substance Use Disorder Services:** Benefits packages must include access to the full-spectrum of mental health and substance use disorder care (e.g., psychotherapy, community-based support groups, peer support, access to essential medications, and a range of other coordinated services designed to support holistic and person-centered care).
 - **Prescription Drugs:** Universal health care reform must work to lower the cost of prescription drugs and ensure that individuals have access to the medications they need. Reform must build on the protections for prescription drug pricing already present in the Medicaid and Medicare programs including: the ability to negotiate the price of prescription drugs with manufacturers and caps on copayments for prescription drugs. Prescription medications must be covered without copayments and without unnecessary barriers like prior authorization and step therapy for critical medications, including expanded access and coverage for over the counter contraceptives.
 - **Long-Term Supports and Services (LTSS):** RJ includes the right to raise our families in safe and sustainable communities. To realize this right, universal health care reform must make LTSS, the daily living care that supports people with disabilities, available and affordable to all who need it. This must include home and community based services (HCBS). People should not have to leave their children, parents, partners, and communities to receive the care that they need, yet private plans and Medicare have excluded caregiver supports and home and community based services, including mental health services and supports. Additionally, Medicaid's current structure allows states to limit and cap access to HCBS in ways that they cannot for other services. Universal health care must include an entitlement to HCBS and bar requirements of institutionalization, family separation, or custody relinquishment. Reform must also incentivize a comprehensive provider network and address the home and community based workforce crisis. Ensuring that caregivers receive adequate wages and benefits is critical to achieving RJ.
 - **Vision, hearing, and dental services:** Coverage must include vision, hearing, and dental services to help ensure the well-being of an individual. For example, dental coverage is a RJ imperative as poor oral health has been linked to complications such as [low birthweight and preterm birth](#).
 - **Whole-person care:** Reform must address the social and structural determinants of health and reproductive futures, such as access to culturally congruent food, economic and housing stability, comprehensive sexuality education, safe drinking water, and adequate sanitation. This can involve furthering whole-person care models that support care coordination between medical and social services [without requiring coercing enrollees into participating or disclosing personal information](#) in order to access health care. Reform must also include strategies to combat structural racism, ableism, sexism, classism, xenophobia, cisheteropatriarchy, and ageism.

6. Health care is affordable for everyone.

Premiums, deductibles, copayments and cost-sharing requirements prevent meaningful access to health care services and should not exist for low-income people, including current Medicaid enrollees. Cost-sharing must also provide protections for people with disabilities, those with chronic conditions, and others who may have heightened health care needs. Any costs to accessing health care should be limited to those with the highest incomes and must be reasonable and predictable for both individuals and families.

7. Health care is confidential for everyone.

To protect the right to bodily autonomy, all people, including minors, must be able to make confidential sexual and reproductive health care decisions, especially when seeking stigmatized services. Amidst the increasing criminalization of these vital services, individuals must be able to access care without fear of legal repercussions or immigration enforcement. Minors should have the right to access sexual, reproductive, and gender-affirming health care without parental or guardian consent or notification. Strengthening patient privacy protections is crucial to minimize the use and disclosure of protected health information and preempt the state laws that undermine these fundamental rights.

8. People have uninterrupted access to care and can enforce their rights.

RJ requires robust enforcement mechanisms to protect individuals' rights. These must include:

- **Court access and robust due process protections.** All people must be guaranteed robust due process protections and effective methods of redress to resolve barriers to health care such as denials, delays, or terminations of eligibility or benefits through a fair, accessible, and efficient administrative system. These protections must include: notice, including effective and linguistically appropriate written notice of decisions and the facts and legal bases used to reach them; hearing rights; continuation of benefits during a review of a termination, suspension, or reduction in coverage (aid pending). Medicaid's procedural protections, such as notice, hearing rights, and continuing aid pending review, should be used as a floor for reform.
- **No one is denied health care, including sexual, reproductive, or gender-affirming health services, due to an institutional or individual provider's biases or personal beliefs about religion and morality.** Reform should include a right to receive immediate referrals if needed and to know whether network providers are religiously affiliated and what services these providers refuse to offer. If the services an enrollee needs are not available in-network due to religious restrictions, the enrollee should be able to immediately access those services out of network at no additional cost. In medical emergencies, including emergencies that require abortion as the necessary stabilizing treatment, the health and well-being of enrollees should override providers' beliefs.
- **Public education and outreach.** For these due process mechanisms to be effective, reform must include public education funding to inform the public of their rights and provide them with the tools and access to understand and navigate the system. This includes access to a multitude of accessible resources both in person, on-demand, and telephonic in the language of the individual's choice.

Advocates for Youth (AFY) envisions a society in which all young people are valued, respected and treated with dignity; sexuality is accepted as a healthy part of being human; and youth sexual development is normalized and embraced.

Contact: Amber Barcel, Director of Public Policy, amber.barcel@advocatesforyouth.org

In Our Own Voice: National Black Women's Reproductive Justice Agenda (IOOV) is a national-state partnership focused on lifting up the voices of Black women leaders at the national and regional levels in our fight to secure Reproductive Justice for all women, girls, and gender-expansive individuals.

Contact: Camille Kidd, Senior Manager of Federal Advocacy, camille@blackrj.org

The National Asian Pacific American Women's Forum (NAPAWF) builds collective power with AAPI women and girls so that we can have full agency over our lives, our families, and our communities.

Contact: Tuyet Duong, Chief Policy and Government Affairs Officer, tduong@napawf.org

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved communities.

Contact: Madeline Morcelle, Senior Attorney, morcelle@healthlaw.org

The National Latina Institute for Reproductive Justice (Latina Institute) fights for equal access to reproductive health for Latina/x communities because all of us should have the power to make informed decisions about our bodies, families, and futures.

Contact: Salen Andrews, Policy Associate, sandrews@latinainstitute.org

Unite for Reproductive & Gender Equity (URGE) envisions a liberated world where we can live with justice, love freely, express our gender and sexuality, and define and create families of our choosing.

Contact: Hope Jackson, Deputy Director of Programs and Policy, hjackson@urge.org, Daniela Ochoa-Diaz, Senior Policy Director, dochoadiaz@urge.org

These *Principles* were co-authored by Rolonda Donelson, Maeve McKean Women's Law & Public Policy Fellow, NHeLP; Chelsea Gonzalez, Law and Policy Analyst, AFY; and Madeline Morcelle, NHeLP. Salen Andrews, Latina Institute; Tuyet Duong, NAPAWF; Hope Jackson, URGE; and Camille Kidd, IOOV were critical co-visioners and partners in this effort. We also thank Ann Marie Benitez, Senior Director of Government Relations, Latina Institute; Bridgette Jackson, Policy Director, IOOV; Connie Choi, Chief Program & Strategy Officer, NAPAWF; Fabiola De Liban, Sexual and Reproductive Health Director, NHeLP; Jennifer Lav, Senior Attorney, NHeLP; Virginia Lucy, Communications Director, NAPAWF; and Daniela Ochoa-Diaz, Senior Policy Director, URGE, for their review and feedback.