

The Case for Low-Income Women's Access to Reproductive Health Care

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Regardless of conservative lawmakers' moral and religious justifications, American society cannot afford to restrict low-income women's independence, economic opportunity, health, and ability to plan for pregnancy by limiting their access to reproductive health care. The World Health Organization defines reproductive health as:

The right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.<sup>1</sup>

This lack of access to reproductive education, counseling, and contraception compromises the health of America's low-income women and their children.<sup>2</sup> Women in their 20s "are most at risk for an unintended pregnancy" but are "least likely to be able to afford contraception."<sup>3</sup> The rate of unintended pregnancy is highest among poor and low-income women between the ages of 18 and 24. This statistic makes the need for reproductive health care, which includes education, counseling, and contraceptive resources, especially pertinent for America's young, low-income women.<sup>4</sup> But reproductive health care is costly for both insured and uninsured women in the United States; out-of-pocket spending on oral contraceptives can account for 30% of privately

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<sup>1</sup> "Reproductive Health," *World Health Organization*, [http://www.who.int/topics/reproductive\\_health/en/](http://www.who.int/topics/reproductive_health/en/) (accessed April 4, 2013).

<sup>2</sup> "Why the Affordable Care Act Matters for Women: Improving Health Coverage for Lower-Income Women," *National Partnership for Women and Families*, March 2012, [http://www.nationalpartnership.org/site/DocServer/LOWER\\_INCOME.pdf?docID=10005](http://www.nationalpartnership.org/site/DocServer/LOWER_INCOME.pdf?docID=10005) (accessed March 28, 2013).

<sup>3</sup> Jessica Arons, Lucy Panza, and Lindsay Rosenthal, "Young Women and Reproductive Health Care," *Center for American Progress*, July 30, 2012, <http://www.americanprogress.org/issues/women/news/2012/07/30/11863/young-women-and-reproductive-health-care/> (accessed March 28, 2013).

<sup>4</sup> "Facts on Unintended Pregnancy in the United States," *Guttmacher Institute*, January 2012, <http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html> (accessed Jan. 10, 2013).

insured women's health care expenses and 68% of uninsured women's.<sup>5</sup> Because of the overall health benefits and high costs of consistent contraception, low-income women deserve to have insurance companies or Medicaid cover the costs of the Contraceptive Preventative Services created under the 2010 Affordable Care Act without cost-sharing, regardless of the religious affiliation of their employers. "For every dollar spent on voluntary family planning services to prevent unintended pregnancy, about \$4 are saved in short-term costs to the government for medical care for the pregnancy and for 1 year of infant care after the birth."<sup>6</sup> Having access to contraception, reproductive education, and counseling will not only improve a low-income woman's health, economic opportunity, and her ability to plan for pregnancy, but this coverage will also benefit her child's health and economic opportunities, as well as the stability of the family.

### **The Affordable Care Act**

By limiting low-income women's access to reproductive health care, particularly contraception, America denies its women *and* their children of healthy births, as well as resources for safe, successful family planning. According to the Wisconsin Alliance for Women's Health, "Reproductive health care is a prerequisite for women's social, economic and human development. When women lack access to safe, comprehensive reproductive health care,

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<sup>5</sup> Jessica Arons, Lucy Panza, and Lindsay Rosenthal, "Young Women and Reproductive Health Care," *Center for American Progress*, July 30, 2012, <http://www.americanprogress.org/issues/women/news/2012/07/30/11863/young-women-and-reproductive-health-care/> (accessed March 28, 2013).

<sup>6</sup> William D. Mosher, Jo Jones, and Joyce C. Abma, "Intended and Unintended Births in the United States: 1982-2010," *Centers for Disease Control and Prevention*, July 24, 2012, <http://www.cdc.gov/nchs/data/nhsr/nhsr055.pdf> (accessed March 27, 2013).

the consequences can be damaging.”<sup>7</sup> These consequences for low-income women can include preventive care failures, such as unintended pregnancies, as well as general reproductive health failures, such as infertility. In 2006, low-income women had six times more unintended pregnancies than wealthier women living in the United States. This statistic suggests that a gap exists between the poor and more affluent women’s access to reproductive health care.<sup>8</sup> For instance, between 1994 and 2001, the rate of unintended pregnancies among all fertile women below the poverty line increased by 44%, while this rate decreased among all women at or above 200% of the poverty line.<sup>9</sup> This increase in the number of poor women’s unintended pregnancies and decrease in the number of wealthier women’s unintended pregnancies indicate the disparity in reproductive and family planning resources available to low-income women.

In order to combat this disparity, the Obama administration strived to make preventive services affordable and accessible in the 2010 Affordable Care Act (ACA). ACA makes “prevention more affordable and accessible for all Americans by requiring most health plans to cover recommended preventive services without cost sharing.”<sup>10</sup> This legislation ensured that 54 million Americans with private health insurance plans would be able to gain these services with zero cost sharing. However, further measures had to be taken so that new insurance plans created under ACA would also cover the costs of preventive services, just as private health insurance

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<sup>7</sup> “What is Reproductive Health,” *Wisconsin Alliance for Women’s Health*, <http://www.wiawh.org/resourcecenter/informationlearninghouse/whatisrh.aspx> (accessed Jan. 8, 2013).

<sup>8</sup> “Facts on Unintended Pregnancy in the United States,” *Guttmacher Institute*, January 2012, <http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html> (accessed Jan. 10, 2013).

<sup>9</sup> Lawrence B. Finer and Stanley K. Henshaw, “Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001,” *Perspectives on Sexual and Reproductive Health*, 2006, 38(2): 94, <http://www.guttmacher.org/pubs/journals/3809006.pdf> (accessed Jan. 10, 2013).

<sup>10</sup> “Affordable Care Act Rules on Expanding Access to Preventive Services for Women,” *HealthCare.gov*, February 13, 2013, <http://www.healthcare.gov/news/factsheets/2011/08/womensprevention08012011a.html> (accessed March 19, 2013).

did.<sup>11</sup> Thus, on August 1, 2011, the United States Department of Health and Human Services created the “Guidelines for Women’s Preventive Services.”<sup>12</sup> The Affordable Care Act’s preventive services provision provides women with counseling and guidance for prenatal care, tests, screenings, and no-cost doctor visits throughout their pregnancies.<sup>13</sup> These screenings check women for alcohol misuse to help prevent fetal alcohol syndrome, tobacco use to help prevent premature birth, gestational diabetes, and iron deficiency anemia to help prevent low birth weight and postpartum depression.<sup>14</sup> Moreover, the ACA provision also requires women to receive counseling and education on how to breastfeed, which benefits the health of both mother and child (see pages 15-16).<sup>15</sup> The new health plans created by ACA began covering the costs of these services in August 2012.<sup>16</sup>

By eliminating the cost sharing of services such as contraception, the Affordable Care Act allows women to improve their personal health, their children’s health, their economic opportunities, and the stability of their families. Because of this 2011 ruling, the women who arguably benefit most from ACA, America’s low-income women who otherwise could not afford preventive services like contraception, now have access to “comprehensive quality health

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<sup>11</sup> “Affordable Care Act Rules on Expanding Access to Preventive Services for Women,” *HealthCare.gov*, February 13, 2013, <http://www.healthcare.gov/news/factsheets/2011/08/womensprevention08012011a.html> (accessed March 19, 2013).

<sup>12</sup> “Women’s Preventive Services: Required Health Plan Coverage Guidelines,” *Health Resources and Services Administration*, <http://www.hrsa.gov/womensguidelines/> (accessed March 19, 2013).

<sup>13</sup> Adam Sonfield, “Beyond Contraception,” *Guttmacher Policy Review*, Fall 2012, <http://www.guttmacher.org/pubs/gpr/15/4/gpr150418.html> (accessed March 28, 2013).

<sup>14</sup> *IBID.*

<sup>15</sup> *IBID.*

<sup>16</sup> “Affordable Care Act Rules on Expanding Access to Preventive Services for Women,” *HealthCare.gov*, February 13, 2013, <http://www.healthcare.gov/news/factsheets/2011/08/womensprevention08012011a.html> (accessed March 19, 2013).

care.”<sup>17</sup> This access allows low-income women to better care for their own health and the health of their families, giving them the opportunity to participate in the workforce, contribute to society, and earn a higher income.

While this paper highlights the contraceptive services and reproductive health care that the Affordable Care Act makes available to low-income women, it is worth noting that ACA will also establish comprehensive sexuality education programs for US teens.<sup>18</sup> ACA funds the Personal Responsibility Education Program (PREP) with \$75 million per year for five years, which states and local communities can apply to for grants.<sup>19</sup> In these programs, adolescents can expect to learn about abstinence and contraception, which should also help to reduce the unintended pregnancy rate among teenagers.

### **Unintended Pregnancy**

A 2012 report by the United States Department of Health and Human Services found that between 2006 and 2010, women below the poverty line claimed that 53% of their births in the past five years were intended. However, during this same time period, women earning family incomes that were 400% of the poverty line or higher claimed that 82% of their births were intended.<sup>20</sup> This nearly 30% difference in the intended pregnancy rate between low-income and

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<sup>17</sup> “Affordable Care Act Rules on Expanding Access to Preventive Services for Women,” *HealthCare.gov*, February 13, 2013, <http://www.healthcare.gov/news/factsheets/2011/08/womensprevention08012011a.html> (accessed March 19, 2013).

<sup>18</sup> “Why the Affordable Care Act Matters for Women: Comprehensive Sex Education for Teens,” *National Partnership for Women and Families*, March 2012, [http://www.nationalpartnership.org/site/DocServer/SEX\\_EDUCATION.pdf?docID=10010](http://www.nationalpartnership.org/site/DocServer/SEX_EDUCATION.pdf?docID=10010) (accessed March 28, 2013).

<sup>19</sup> *IBID.*

<sup>20</sup> William D. Mosher, Jo Jones, and Joyce C. Abma, “Intended and Unintended Births in the United States: 1982-2010,” *Centers for Disease Control and Prevention*, July 24, 2012, <http://www.cdc.gov/nchs/data/nhsr/nhsr055.pdf> (accessed March 27, 2013).

wealthier women illustrates the stark contrast in women's access to the reproductive health care that could prevent unintended pregnancies. If nearly half of all low-income women's pregnancies are unplanned while less than a fifth of high-income women's pregnancies are unplanned, then American society must increase low-income women's access to reproductive health care. With this access to care, low-income women can have the opportunity to eliminate these continuously high rates of unintended births among their population.

While access to contraceptive methods, such as birth control pills, could provide the most immediate remedy to these high rates of unintended pregnancy, other forms of reproductive health care can help low-income women better plan their pregnancies. This paper cannot report on all of the effects of reproductive health care services made available to low-income women through the Affordable Care Act because many components of those services have yet to be finalized and implemented. But this new access to contraception, contraceptive counseling, and "comprehensive quality health care," will hopefully reduce low-income women's rates of unintended pregnancy.<sup>21</sup>

### **The Religious Arguments**

Despite the Obama administration's efforts to make comprehensive, quality health care accessible for *all* American women through the Affordable Care Act, the federal government currently exempts religious employers from providing contraceptive services to their employees. These employers refuse to cover female employees' reproductive care services in their health

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<sup>21</sup> "Affordable Care Act Rules on Expanding Access to Preventive Services for Women," *HealthCare.gov*, February 13, 2013, <http://www.healthcare.gov/news/factsheets/2011/08/womensprevention08012011a.html> (accessed March 19, 2013).

plans due to religious objections to contraception.<sup>22</sup> In order to earn exemption from providing contraceptive services, religious organizations must meet the following criteria:

1. The inculcation of religious values is the purpose of the organization.
2. The organization primarily employs persons who share the religious tenets of the organization.
3. The organization serves primarily persons who share the religious tenets of the organization.
4. The organization is a nonprofit organization as described in section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.<sup>23</sup>

According to these standards, religious universities and hospitals do not qualify as exempt organizations. These rules only eliminate individual churches, “institutions that serve and employ primarily members of their own faith,” from providing female employees with contraceptive services.<sup>24</sup> Following the installation of these criteria in the Interim Final Ruling on August 3, 2011, Father John Jenkins, C.S.C., President of the University of Notre Dame objected to the federal government’s requirement that his Catholic university “provide in their insurance plans abortion-inducing drugs, contraceptives and sterilization procedures, which are contrary to Catholic teaching.”<sup>25</sup> While the University of Notre Dame’s frustration is understandable, the university and other similar religious organizations need to realize that providing access to contraceptive measures is both a means to reducing abortion and a critical component of their female employees’ overall health and well-being. On February 10, 2012, President Obama

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<sup>22</sup> “Affordable Care Act Rules on Expanding Access to Preventive Services for Women,” *HealthCare.gov*, February 13, 2013, <http://www.healthcare.gov/news/factsheets/2011/08/womensprevention08012011a.html> (accessed March 19, 2013).

<sup>23</sup> “Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act.” *U.S. Government Printing Office*, August 3, 2011, <http://www.gpo.gov/fdsys/pkg/FR-2011-08-03/pdf/2011-19684.pdf> (accessed March 19, 2013).

<sup>24</sup> “Notre Dame: Why We’re Suing Over Birth-Control Mandate,” *The Wall Street Journal*, May 21, 2012, <http://blogs.wsj.com/washwire/2012/05/21/notre-dame-why-were-suing-over-birth-control-mandate/> (accessed April 4, 2013).

<sup>25</sup> IBID.

announced that the Affordable Care Act would make a special exemption for these religiously affiliated charities, universities, schools, and hospitals. Yet even with this exemption, Notre Dame's president, Father Jenkins, upheld his argument that requiring employees' access to contraceptive services constitutes a "fundamental issue of religious freedom."<sup>26</sup>

I disagree with Father Jenkins and conservative politicians that this controversy embodies an issue of religious freedom. Because this exemption issued on February 10, 2012 would require health insurance companies to offer a side benefit to cover the costs for employees' contraceptive services, religious institutions like Notre Dame would not technically be paying for employees' reproductive health care.<sup>27</sup> As clarified by David Axelrod, former Senior Advisor to President Obama:

I think that the administration struck a common sense rule here that doesn't ask these institutions in any way to sponsor contraceptive services for their employees, many of whom aren't Catholic, but gives the employees a chance to access those services through a third party. These institutions don't have to pay for [contraceptive services for their employees and] don't have to sponsor it.<sup>28</sup>

For those who are skeptical as to whether or not religious institutions are truly exempt from covering these contraceptive costs, the answer may not be evident until all components of the Affordable Care Act are finalized and implemented. Just three months ago, U.S. District Judge Robert L. Miller dismissed Notre Dame's lawsuit against the Obama administration's

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<sup>26</sup> "Notre Dame: Why We're Suing Over Birth-Control Mandate," *The Wall Street Journal*, May 21, 2012, <http://blogs.wsj.com/washwire/2012/05/21/notre-dame-why-were-suing-over-birth-control-mandate/> (accessed April 4, 2013).

<sup>27</sup> Helene Cooper and Laurie Goodstein, "Rule Shift on Birth Control Is Concession to Obama Allies," *The New York Times*, February 10, 2012, <http://www.nytimes.com/2012/02/11/health/policy/obama-to-offer-accommodation-on-birth-control-rule-officials-say.html?hp> (accessed April 4, 2013).

<sup>28</sup> Devin Dwyer, "Notre Dame, Catholic Dioceses Sue Obama Over Contraception Mandate," *ABC News*, May 21, 2012, <http://abcnews.go.com/blogs/politics/2012/05/notre-dame-catholic-dioceses-sue-obama-over-contraception-mandate/> (accessed April 4, 2013).

requirement that the Catholic university cover the cost of employees' birth control.<sup>29</sup> Until these federal policies are finalized, skeptics should realize that insurance companies have an incentive to cover contraceptive costs; not only do they gain back the costs of providing contraception with lower birth rates, but they also accrue lower health care-related costs by avoiding more pregnancies and protecting the overall health of these women.<sup>30</sup>

In addition, these tensions between Roman Catholic officials and federal government leaders have not been limited to Catholic universities; they have also affected America's Catholic hospital systems. Catholic-sponsored medical centers have increasingly partnered with smaller, financially weaker, secular hospitals. As a result of these partnerships, the debate over reproductive health care coverage has not only threatened female hospital employees' access to contraceptive services but also the reproductive health care treatments available to female patients.<sup>31</sup> In 2010, one sixth of Americans were treated at Catholic hospitals.<sup>32</sup> So the confusion over applying life-saving medical procedures versus adhering to religious and ethical doctrines in these Catholic hospitals will continue to threaten thousands of American females' lives until a legal settlement is reached. Low-income women, especially those in rural areas with few health care options, will lose access to life-saving reproductive medical procedures if a Catholic health company were to take over their nearest medical system. The low-income women of Kentucky almost faced this issue before Governor Steve Beshear blocked Catholic Health Initiative's

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<sup>29</sup> Elise Viebeck, "Judge boots Notre Dame's case against birth-control mandate," *The Hill*, January 4, 2013, <http://thehill.com/blogs/healthwatch/legal-challenges/275599-judge-boots-notre-dames-case-against-hhs-mandate> (accessed April 4, 2013).

<sup>30</sup> Robert Pear, "Birth Control Rule Altered to Allay Religious Objections," *The New York Times*, February 1, 2013, <http://www.nytimes.com/2013/02/02/us/politics/white-house-proposes-compromise-on-contraception-coverage.html?ref=contraception> (accessed April 4, 2013).

<sup>31</sup> Reed Abelson, "Catholic Hospitals Expand, Religious Strings Attached," *The New York Times*, February 20, 2012, <http://www.nytimes.com/2012/02/21/health/policy/growth-of-catholic-hospitals-may-limit-access-to-reproductive-care.html> (accessed April 4, 2013).

<sup>32</sup> IBID.

merger with the University of Louisville Hospital on December 30, 2011.<sup>33</sup> This merger would have restricted reproductive services available to low-income women all across the state of Kentucky. However, because the majority of Catholic hospitals' funding comes from public insurance programs like Medicare and Medicaid and not the Catholic Church, the controversy continues over whether these hospital systems should adhere to political or religious authority.<sup>34</sup>

Moreover, Sister Carol Keehan, president of the Catholic Health Association, initially approved of President Obama's February 10, 2012 compromise on the religious issue. However, Catholic bishops struck back, protesting that no employee at any Catholic-affiliated institution should have access to contraception, regardless of whether the hospital or the insurance company pays for that access.<sup>35</sup> Those Catholic hospital employees seeking coverage for their contraceptive services will often times turn to federally funded programs like Title X clinics. As a result, taxpayers end up covering the costs for over 700,000 full and part-time employees of religiously affiliated businesses even though ACA's accommodation now requires health insurance companies to cover those costs.<sup>36</sup> This lack of compliance by Catholic hospital systems will demand more federal dollars to cover the cost of contraceptive services obtained at public clinics, the costs of unintended pregnancies that result from women losing their insurance-covered contraception, and the health issues that can result when women who need contraceptive

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<sup>33</sup> "Gov. Beshear denies approval of hospital merger," *WAVE News*, January 6, 2012, <http://www.wave3.com/story/16417913/gov-beshear-denies-approval-of-hospital-merger> (accessed April 4, 2013).

<sup>34</sup> "Women's Health Care at Risk," *The New York Times*, February 28, 2012, [http://www.nytimes.com/2012/02/29/opinion/womens-health-care-at-risk.html?hp&\\_r=1&](http://www.nytimes.com/2012/02/29/opinion/womens-health-care-at-risk.html?hp&_r=1&) (accessed April 4, 2013).

<sup>35</sup> Louis Uttley, "Employees Need Birth Control Coverage Mandate," *The Nation*, February 17, 2012, <http://www.thenation.com/article/166335/employees-need-birth-control-coverage-mandate#> (accessed April 4, 2013).

<sup>36</sup> IBID.

services for the sake of their reproductive health are denied access to them.<sup>37</sup> But employees or patients of these Catholic hospital systems are not required to use this insurance-covered contraception, especially if their own religious beliefs do not condone it. Federal lawmakers created ACA in order to increase women's *access* to contraceptive measures, giving them additional options, not requirements, for their reproductive health care procedures.

For low-income women who do not have jobs at these religious institutions, this religious exemption should not pose a problem to their obtaining insurance coverage for their reproductive health care. Moreover, non-profit organizations that have previously not covered contraceptive measures in their health plans for religious reasons must begin to cover their employees' contraceptive services beginning on August 1, 2013.<sup>38</sup> The federal government needs to continue making progress towards increasing all women's accessibility to reproductive health care coverage. Low-income women and those working for religious institutions that will not be forced to cover contraceptive measures starting in August 2013 especially benefit from the government's continued progress. Hopefully this change in coverage will prompt further policy improvements regarding low-income women's access to reproductive health care, even with the current political arguments regarding religious freedom.

### **Family Planning**

Contraception accessibility is one of the most critical components of women's reproductive health care because it gives them the power to plan their families. According to the

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<sup>37</sup> Louis Uttley, "Employees Need Birth Control Coverage Mandate," *The Nation*, February 17, 2012, <http://www.thenation.com/article/166335/employees-need-birth-control-coverage-mandate#> (accessed April 4, 2013).

<sup>38</sup> "Affordable Care Act Rules on Expanding Access to Preventive Services for Women," *HealthCare.gov*, February 13, 2013, <http://www.healthcare.gov/news/factsheets/2011/08/womensprevention08012011a.html> (accessed March 19, 2013).

Michigan Department of Community Health, “family planning services provide information and the means for men and women to exercise personal choice in determining the number and spacing of their children.”<sup>39</sup> The Centers for Disease Control and Prevention (CDC) claimed family planning to be one of the ten greatest public health achievements of the 20<sup>th</sup> century:

Smaller families and longer birth intervals have contributed to the better health of infants, children, and women, and have improved the social and economic role of women. Despite high failure rates, traditional methods of fertility control contributed to the decline in family size. Modern contraception and reproductive health-care systems that became available later in the century further improved couples' ability to plan their families. Publicly supported family planning services prevent an estimated 1.3 million unintended pregnancies annually.<sup>40</sup>

When women do not have to worry about obtaining and affording their contraceptive measures because health insurance covers the costs, not only can they plan births but also space them.<sup>41</sup> Thus, reproductive health care empowers women and their spouse's ability to plan and achieve their desired family size and birth spacing.<sup>42</sup> They can make financial and overall health preparations that will improve their child's health and opportunity. In fact, with increased access to reproductive health care, low-income women can complete their schooling, job training, and other methods of increasing their personal capabilities in order to reduce their likelihoods of remaining in poverty, especially as mothers. And ultimately, women who plan their pregnancies through access to contraception will more likely pursue prenatal care, breast-feed their babies,

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<sup>39</sup> “What is Family Planning?” *Michigan Department of Community Health*, [http://www.michigan.gov/documents/mdch/FPnews1\\_319473\\_7.pdf](http://www.michigan.gov/documents/mdch/FPnews1_319473_7.pdf) (accessed April 4, 2013).

<sup>40</sup> “Achievements in Public Health, 1900-1999: Family Planning,” *Morbidity and Mortality Weekly Report*, December 3, 1999, <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4847a1.htm> (accessed March 17, 2013).

<sup>41</sup> “Benefits of Contraceptive Use in the United States,” *Guttmacher Institute*, July 31, 2012, <http://www.guttmacher.org/media/inthenews/2012/07/31/index.html> (accessed Jan. 10, 2013).

<sup>42</sup> Jo Jones, William Mosher, and Kimberly Daniels, “Current Contraceptive Use in the United States, 2006-2010, and Changes in Patterns of Use Since 1995,” *National Health Statistics Reports*, Oct. 18, 2012, <http://www.cdc.gov/nchs/data/nhsr/nhsr060.pdf> (accessed March 27, 2013).

and reduce smoking and drinking habits during pregnancy.<sup>43</sup> Therefore, contraception allows women and their partners to plan their pregnancies and make healthier decisions, benefiting themselves, the lives of their children, and the stability of their families.

### **Teenage Pregnancy Rates**

In addition, access to reproductive health care not only allows women to use contraception and contraceptive counseling as tools for planning their pregnancies, but also has contributed to the declining teenage pregnancy rate in the United States. For example, in 2008, teenage pregnancy in the US dropped to its lowest level in over forty years.<sup>44</sup> In 2008, 7% of all fertile young women between the ages of 15 and 19 got pregnant, versus 42% of fertile young women in the same age group in 1990.<sup>45</sup> Moreover, a 2009 study by the Centers for Disease Control and Prevention found a 37% decrease in the national teen birth rate between 1991 and 2009.<sup>46</sup> Between 1999 and 2009, the same study found an increase in the percentage of teens that used dual methods of contraception during their last intercourse, an increase from 5% to 9%.<sup>47</sup> While an increase in teenagers' use of contraception does not cause the declining teen birth rate, this factor could certainly have an impact on its decline. This potential correlation makes the case for increasing teenagers' access to reproductive health care, especially those in low-income households. After all, the American teen birth rate is six to nine times higher than other

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<sup>43</sup> "Benefits of Contraceptive Use in the United States," *Guttmacher Institute*, July 31, 2012, <http://www.guttmacher.org/media/inthenews/2012/07/31/index.html> (accessed Jan. 10, 2013).

<sup>44</sup> Rebecca Wind, "U.S. Teen Pregnancy Rate at Lowest Level in Nearly 40 Years," *Guttmacher Institute*, February 8, 2012, <http://www.guttmacher.org/media/nr/2012/02/08/index.html> (accessed March 3, 2013).

<sup>45</sup> *IBID.*

<sup>46</sup> K Pazol et al., "Vital Signs: Teen Pregnancy – United States, 1991-2009," *Morbidity and Mortality Weekly Report*, April 8, 2011, <http://www.cdc.gov/mmwr> (accessed March 17, 2013).

<sup>47</sup> *IBID.*

developed countries with the lowest teen birth rates.<sup>48</sup> The United States needs to correct this gap in reproductive health care access, especially for low-income teenage women. For the sake of these females' economic and maternal potential, the additional financial costs that would further burden their low-income families, the health and economic potential of their soon-to-be-born children, and American taxpayers, reproductive health care must be made available to low-income earning females. Without continued promotion of access to contraception and contraceptive counseling across the United States, teenage pregnancy rates could easily begin to rise, which could cause abortion rates to rise as well.

Furthermore, by reducing the number of unintended pregnancies, especially among teenage girls, the United States government can reduce the harm that children born to teen mothers would endure. A 2013 study by *Pediatric & Perinatal Epidemiology* found that pregnant teenagers who were not emotionally ready for pregnancy had an increased chance of delaying prenatal care and using prenatal vitamins, and had increased chances of smoking and drinking.<sup>49</sup>

One example of this delayed prenatal care is failing to learn the value of breastfeeding. Adolescent women not only have the lowest rates of breastfeeding, but they also have some of the highest rates of discontinuing breastfeeding within the first year of their babies' lives.<sup>50</sup> This is troubling, considering that the American Academy of Pediatrics (AAP) recommends that

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<sup>48</sup> K Pazol et al., "Vital Signs: Teen Pregnancy – United States, 1991-2009," *Morbidity and Mortality Weekly Report*, April 8, 2011, <http://www.cdc.gov/mmwr> (accessed March 17, 2013).

<sup>49</sup> Roberta B. Ness et al., "Thoughts on the Future of Reproductive and Perinatal Epidemiology," *Pediatric and Perinatal Epidemiology*, January 2013, <http://onlinelibrary.wiley.com.ezproxy.wlu.edu/doi/10.1111/ppe.12017/full> (accessed March 28, 2013).

<sup>50</sup> Tracy L. Glass et al., "Infant Feeding and Contraceptive Practices Among Adolescents with a High Teen Pregnancy Rate: A 3-Year Retrospective Study," *Journal of Women's Health*, November 9, 2010, <http://ehis.ebscohost.com.ezproxy.wlu.edu/ehost/pdfviewer/pdfviewer?sid=86f21f8e-ff0a-4e52-a311-610ee729c280%40sessionmgr12&vid=5&hid=15> (accessed March 28, 2013).

women breastfeed for at least one year after a child's birth.<sup>51</sup> Breastfeeding provides substantial health benefits to both the mother and her child. Breastfed babies have fewer upper respiratory infections, urinary tract infections, bacterial meningitis, and potentially a lesser chance of developing diabetes, asthma, and leukemia later in life. Mothers who breastfeed their children are less likely to develop postpartum blood loss, premenopausal breast cancer, ovarian cancer, and cardiovascular disease.<sup>52</sup> Thus, low-income teenage girls who are unprepared, let alone who do not know how to care for a baby and themselves, would immediately benefit from access to reproductive health care. For example, studies show that increasing adolescent women's education on the value of breastfeeding improves the breastfeeding rate among teenage mothers.<sup>53</sup> By delaying pregnancy, teenage women have more time to learn beneficial prenatal and postnatal care procedures such as breastfeeding. These young women, especially among the low-income teen population, need to know that their health and *the health of their children* would improve with delayed pregnancy and access to reproductive health care resources. I will later discuss the additional impacts that increased access to contraceptive services and reproductive health care has on children born to low-income women.

### **Impacts on Abortion Rates**

Research shows that reducing unintended pregnancies reduces the likelihood of women seeking abortion. If the United States can provide women with publicly funded contraceptive and family planning services, then the number of unintended pregnancies and subsequent abortions

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<sup>51</sup> Tracy L. Glass et al., "Infant Feeding and Contraceptive Practices Among Adolescents with a High Teen Pregnancy Rate: A 3-Year Retrospective Study," *Journal of Women's Health*, November 9, 2010, <http://ehis.ebscohost.com.ezproxy.wlu.edu/ehost/pdfviewer/pdfviewer?sid=86f21f8e-ff0a-4e52-a311-610ee729c280%40sessionmgr12&vid=5&hid=15> (accessed March 28, 2013).

<sup>52</sup> IBID.

<sup>53</sup> IBID.

would decline, especially among low-income women.<sup>54</sup> Fifty-seven percent of all abortions in 2000 were performed for women living below the federal poverty line.<sup>55</sup> By providing low-income women with contraceptive services that can reduce their rates of unintended pregnancy, the US government can reduce their need to obtain abortions. Those who argue against federal dollars supporting female contraception should know that every dollar invested in helping women prevent their pregnancies saves the US government \$4.02 in the Medicaid expenditures that would have been applied to a woman's care for her baby.<sup>56</sup> Increasing access to contraception and contraceptive counseling could reduce the unintended pregnancy rate and the subsequent need to obtain abortions, as well as save taxpayer dollars.<sup>57</sup>

Conservatives should realize the benefits accrued by providing low-income women access to reproductive health care services. The fact that the overwhelming majority of women who have unintended pregnancies do not take contraceptives suggests that increasing women's access to continuous, dependable contraception could help decrease the abortion rate in the US, especially among low-income women. According to a 2004 study published in *Perspectives on Sexual and Reproductive Health*, 60% of abortion patients were below 200% of the federal poverty level; in a similar 1987 survey, the percentage of abortion patients below 200% of the

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<sup>54</sup> "Facts on Unintended Pregnancy in the United States," *Guttmacher Institute*, January 2012, <http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html> (accessed Jan. 10, 2013).

<sup>55</sup> Brenda Major et al., "Report of the APA Task Force on Mental Health and Abortion," *American Psychological Association*, 2008, <http://www.apa.org/pi/women/programs/abortion/mental-health.pdf> (accessed March 28, 2013).

<sup>56</sup> Rachel Benson Gold et al., "Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System," *Guttmacher Institute*, <http://www.guttmacher.org/pubs/NextSteps.pdf> (accessed March 3, 2013).

<sup>57</sup> "Benefits of Contraceptive Use in the United States," *Guttmacher Institute*, July 31, 2012, <http://www.guttmacher.org/media/inthenews/2012/07/31/index.html> (accessed Jan. 10, 2013).

federal poverty level was 10% lower.<sup>58</sup> But even with this increase in the number of low-income women obtaining abortions between 1987 and 2004, there is limited information available regarding the exact number of abortions obtained by low-income women in the United States. This limited information illustrates the need for further research on reproductive health care and abortion. Knowing the impact that access to contraceptive counseling can have on low-income women's decisions to have abortions could help policymakers continue to improve the Affordable Care Act.

### **The Health Benefits of Oral Contraceptive Pills**

While most American women take oral contraceptive pills (OCPs) primarily as a method of birth control, many women take them for other reasons that impact both their reproductive and overall health. However, a disparity exists in the socioeconomic status of women who have access to these efficient and dependable pills and those who do not. For instance, in 2002, the oral contraceptive pill was the most popular form of contraception among American women across all age groups.<sup>59</sup> However, 42% of the women who used oral contraceptive pills for contraception had attained a college degree versus the 11% who took OCPs that lacked high school degrees.<sup>60</sup> This inequality between the preferred form of contraception among more-educated and less-educated women suggests reduced access to oral contraceptive pills for the latter group.

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<sup>58</sup> Lawrence B. Finer et al., "Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives," *Perspectives on Sexual and Reproductive Health*, September 2005, <http://www.guttmacher.org/pubs/journals/3711005.html> (accessed March 28, 2013).

<sup>59</sup> William D. Mosher et al., "Use of Contraception and Use of Family Planning Services in the United States: 1982-2002," *Centers for Disease Control and Prevention*, December 10, 2004, <http://www.cdc.gov/nchs/data/ad/ad350.pdf> (accessed March 17, 2013).

<sup>60</sup> IBID.

Less-educated women's reduced access to oral contraceptive pills deprives them of a safe and dependable form of contraception, as well as a long-term source of protection for their reproductive health. Lack of access to contraception could jeopardize a young, low-income woman's chances of having children later in her life if she lacks the means to cure her menstrual-related problems. These problems can include treating excessive menstrual bleeding and pain, regulating monthly menstrual cycles, and alleviating other side effects caused by menstrual and hormonal-related diseases.<sup>61</sup> Across all income levels of US women, 14% or over 1.5 million users, take OCPs for non-contraceptive purposes. This statistic illustrates the prevalent need for women's access to contraceptive measures, even for non-contraceptive and overall health reasons.<sup>62</sup>

For example, taking oral contraceptive pills can help young women cure amenorrhea, which occurs when a female has not had her menstrual period in over 90 days or when teenage girls have not started menstruating by the age of 15.<sup>63</sup> OCPs are a proven method for helping young women regulate their menstrual cycles when they are diagnosed with amenorrhea. This inability for the female body to generate the monthly menstrual cycle directly results from hormonal imbalances, which are caused by lifestyle factors such as stress, low body weight, obesity, and excessive exercise.<sup>64</sup>

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<sup>61</sup> Rachel K. Jones, "Beyond Birth Control," *Guttmacher Institute*, November 2011, <http://www.guttmacher.org/pubs/Beyond-Birth-Control.pdf> (accessed March 3, 2013).

<sup>62</sup> IBID.

<sup>63</sup> "Menstruation and the menstrual cycle fact sheet," *Office on Women's Health*, October 21, 2009, <http://www.womenshealth.gov/publications/our-publications/fact-sheet/menstruation.cfm#e> (accessed March 11, 2013).

<sup>64</sup> "Amenorrhea Fact Sheet," *Office of Population Affairs*, <http://www.hhs.gov/opa/pdfs/amenorrhea-fact-sheet.pdf> (accessed March 19, 2013).

According to my pediatrician, Dr. Karen Halsell, M.D., F.A.A.P., the most immediate problem that occurs when a young woman does not have her period is that her bone health and reproductive health are in jeopardy. In order for a woman to have her monthly period, her body needs to produce enough estrogen, and in order for her bones to grow and absorb calcium, her body needs the estrogen generated during the monthly menstrual period. Otherwise, her growing bones cannot take in calcium, and she becomes vulnerable to developing osteopenia, the precursor for osteoporosis. In turn, she would be susceptible to osteoporosis later in life if her hormonal imbalance goes untreated.<sup>65</sup> Therefore, doctors prescribe birth control because it provides the females' bodies with an easy opportunity to regulate hormones, restart the monthly menstrual cycle, and allow their bones to absorb calcium and prevent the development of osteopenia and osteoporosis.

Moreover, with regards to the low-income female population, Dr. Halsell hypothesizes that these women are more susceptible than higher-income women to two hormonal-related diseases: polycystic ovary syndrome and menorrhagia. Both of these diseases are prevalent among obese women, whose heavy weight causes their hormonal imbalances. Polycystic ovary syndrome is most common among overweight teenage girls, particularly those who are Hispanic and African American. Dr. Halsell argues that oral contraceptive agents would be her first response to treating polycystic ovary syndrome because they would immediately regulate the hormonal balance and restart the woman's monthly periods. If overweight, low-income women with polycystic ovary syndrome do not have access to the oral contraceptive pills that could correct their condition, then their ovaries will continue to be damaged by this hormonal

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<sup>65</sup> Dr. Karen Halsell, M.D., F.A.A.P. in discussion with the author, March 20, 2013.

imbalance, damage that will affect their reproductive and overall health, as well as their ability to bear children later in life.

Similarly, Dr. Halsell believes that oral contraceptive pills are the quickest and most effective means to correcting menorrhagia, which occurs when overweight women have extremely dramatic menstrual cycles that include heavy bleeding for at least ten days with repetitive, painful cramping.<sup>66</sup> Menorrhagia can influence a low-income woman's ability to attend school or work, which demonstrates the negative health and economic consequences low-income women must endure if these hormonal-related diseases go untreated.<sup>67</sup> As a result of taking oral contraceptive pills, women with menorrhagia have less dramatic periods, so they will not lose as much blood or time spent at school and work.

These examples of how contraception can have health benefits unrelated to preventing unwanted pregnancies demonstrate further the need for religious institutions to provide their employees with access to reproductive health care. Access to contraception allows women to do more than plan their pregnancies; it allows them to protect both their health and their ability to bear children later in their lives—capabilities of which low-income women have been deprived for too long.

### **Women's Mental Health**

Women who experience unintended pregnancy have a greater risk of experiencing postpartum depression than women with planned pregnancies. This higher chance of developing mental health problems could impede both their abilities to provide the baby with nurturing care

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<sup>66</sup> Dr. Karen Halsell, M.D., F.A.A.P. in discussion with the author, March 20, 2013.

<sup>67</sup> IBID.

and to participate in the workforce.<sup>68</sup> In addition, women bearing unintended children are at greater risk of developing anxiety and experiencing an overall decline in their psychological well-being. This finding illustrates the impact that lack of contraceptive access can have on women's mental health and subsequently, their abilities to care for themselves and their unplanned children.<sup>69</sup>

With regards to abortion, studies by the American Psychological Association show that women who undergo a first-trimester abortion to end an unintended pregnancy are at no greater risk of developing mental health problems than women who decide to deliver the unintended child.<sup>70</sup> But the fact that women can still develop mental health problems from obtaining an abortion makes the additional case for increasing their access to contraception and contraceptive counseling.

Poverty in and of itself is already a concern for women's levels of mental health. So low-income women experiencing unintended pregnancies are especially vulnerable to mental health problems, especially when they lack the resources for prenatal care.<sup>71</sup> The barriers to low-income women's access to contraceptive measures must be removed in order to prevent the potential

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<sup>68</sup> "Consequences of Unplanned Pregnancy," *The National Campaign*, <http://www.thenationalcampaign.org/resources/pdf/FactSheet-Consequences.pdf> (accessed March 11, 2013).

<sup>69</sup> Jessica D. Gipson, Michael A. Koenig, and Michelle J. Hindin, "The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature," *Studies in Family Planning*, March 2008, <http://www.jstor.org.ezproxy.wlu.edu/stable/pdfplus/20454434.pdf?acceptTC=true> (accessed March 28, 2013).

<sup>70</sup> Joerg Dreweke, "Abortion and Mental Health," *Guttmacher Institute*, January 2011, <http://www.guttmacher.org/media/evidencecheck/2011/01/31/Advisory-Abortion-Mental-Health.pdf> (accessed March 28, 2013).

<sup>71</sup> Catherine DeCarlo Santiago, Stacey Kaltman, and Jeanne Miranda, "Poverty and Mental Health," *Journal of Clinical Psychology*, February 2013, <http://ehis.ebscohost.com.ezproxy.wlu.edu/ehost/detail?vid=5&sid=ef6b6222-9348-47fe-a0f1-11146086b72e%40sessionmgr111&hid=106&bdata=JnNpdGU9ZWwhvc3QtbGl2ZQ%3d%3d#db=a9h&AN=84637540> (accessed March 28, 2013).

worsening of their already vulnerable mental health states. After all, poor mental health will only impede their ability to provide nurturing care for their children.

### **Impacts on Children**

Women, regardless of their income, who have unplanned pregnancies are more likely to delay prenatal care. This delay increases the existing risk of an unintended pregnancy resulting in a preterm delivery or a low-birth-weight baby.<sup>72</sup> Between 2006 and 2010, 12% of unintended pregnancies across all income levels resulted in low-birth-weight babies versus 7.2% that resulted from planned pregnancies.<sup>73</sup> Women who have unintended pregnancies are more likely to jeopardize their own health and the health of their unborn children by failing to seek proper prenatal care. For women across all economic levels, 19% having unintended pregnancies either did not receive prenatal care until the second trimester or failed to seek care at all versus the 8.2% of women with planned pregnancies who delayed seeking care.<sup>74</sup> Delaying prenatal care increases the mother's chances of failing to breastfeed, which can create severe health risks for both herself and her child (see pages 15-16). Delaying or all together failing to begin prenatal care services can also result in the mother's smoking or drinking during pregnancy. Smoking increases the risk of delivering a low-birth-weight baby, having a miscarriage, the baby being born preterm, or the baby suffering from severe illnesses during early childhood.<sup>75</sup> With access to reproductive education, counseling, and contraception, low-income women have the ability to

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<sup>72</sup> "Consequences of Unplanned Pregnancy," *The National Campaign*, <http://www.thenationalcampaign.org/resources/pdf/FactSheet-Consequences.pdf> (accessed March 11, 2013).

<sup>73</sup> William D. Mosher, Jo Jones, and Joyce C. Abma, "Intended and Unintended Births in the United States: 1982-2010," *Centers for Disease Control and Prevention*, July 24, 2012, <http://www.cdc.gov/nchs/data/nhsr/nhsr055.pdf> (accessed March 27, 2013).

<sup>74</sup> IBID.

<sup>75</sup> William D. Mosher, Jo Jones, and Joyce C. Abma, "Intended and Unintended Births in the United States: 1982-2010," *Centers for Disease Control and Prevention*, July 24, 2012, <http://www.cdc.gov/nchs/data/nhsr/nhsr055.pdf> (accessed March 27, 2013).

plan their families and reduce these potential health consequences that affect both themselves and their children.

Moreover, research has shown possible correlations between unintended pregnancies and the unplanned children's potential educational attainment and opportunities. A 2001 study by the National Center for Education Statistics found that two-year-old children born from unplanned pregnancies had "significantly lower cognitive test scores when compared to children born as the result of an intended pregnancy."<sup>76</sup> Furthermore, children born as a result of unintended pregnancies statistically have lower standardized test scores, lower levels of educational attainment, and higher poverty rates.<sup>77</sup> These findings demonstrate a potential correlation between their mother's lack of reproductive health care and the child's long-term outcomes. Studies have shown that children from unplanned pregnancies are less well adapted than their peers at age nine, have lower levels of self-esteem as 23-year-old adults, and are at greater risk for depression and psychiatric problems in their late twenties and early thirties.<sup>78</sup> While many other factors contribute to these children's results, their birth from an unintended pregnancy could be correlated to these unfortunate long-term outcomes.

### **Title X Family Planning Program**

Surprisingly for some observers, the Affordable Care Act's efforts to increase all women's access to necessary health services such as contraception are not revolutionary. For

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<sup>76</sup> "Consequences of Unplanned Pregnancy," *The National Campaign*, <http://www.thenationalcampaign.org/resources/pdf/FactSheet-Consequences.pdf> (accessed March 11, 2013).

<sup>77</sup> Adam Thomas, "Policy Prescription for Preventing Unintended Pregnancies," *Brookings Social Genome Project Conference*, November 8, 2011, [http://www.childtrends.org/Files//Child\\_Trends-2011\\_11\\_08\\_SP\\_BrookPreventPreg.pdf](http://www.childtrends.org/Files//Child_Trends-2011_11_08_SP_BrookPreventPreg.pdf) (accessed March 28, 2013).

<sup>78</sup> "Consequences of Unplanned Pregnancy," *The National Campaign*, <http://www.thenationalcampaign.org/resources/pdf/FactSheet-Consequences.pdf> (accessed March 11, 2013).

over forty years, a Federal grant program has been in place to provide low-income families with confidential contraceptive services, education, counseling, and information on family planning.<sup>79</sup>

In 1970, Congress passed Title X of the Public Health Service Act. Today's Title X Family Planning program assists several million women and men across America each year through their local health departments, community health centers, hospitals, and faith-based organizations.<sup>80</sup> A 2012 report by the National Family Planning and Reproductive Health Association stated that 69% of Title X patients have incomes at or below the federal poverty level, while 91% of total patients have incomes at or below 250% of the federal poverty level.<sup>81</sup> The substantial number of low-income patients reflects the poor's lack of access to reproductive care and their subsequently high demand for it through publicly funded programs such as Title X.

In addition to offering pregnancy tests, Title X programs provide women with nondirective counseling and referrals for prenatal care, adoption, and abortion.<sup>82</sup> Title X funding cannot be spent on abortion anywhere in the United States.<sup>83</sup> While the number of women who use Title X Family Planning services varies each year, the Federal grant program had a 29% increase in demand between 1995 and 2002. In 1995, 4.2 million women used the Title X family

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<sup>79</sup> "History of Title X," *Office of Population Affairs*, <http://www.hhs.gov/opa/title-x-family-planning/> (accessed March 19, 2013).

<sup>80</sup> IBID.

<sup>81</sup> "Title X Fact Sheet," *National Family Planning & Reproductive Health Association*, March 2012, <http://www.nationalfamilyplanning.org/document.doc?id=499> (accessed March 28, 2013).

<sup>82</sup> Rachel Benson Gold et al., "Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System," *Guttmacher Institute*, <http://www.guttmacher.org/pubs/NextSteps.pdf> (accessed March 3, 2013).

<sup>83</sup> "Title X Family-Planning Services: Fast Facts," *NARAL Pro-Choice America*, <http://www.prochoiceamerica.org/media/fact-sheets/birth-control-family-planning-title-x-fast-facts.pdf> (accessed March 27, 2013).

clinics for their health services versus the 5.4 million women who used them in 2002.<sup>84</sup> By 2006, over nine million women received publicly funded contraceptive services, and two thirds of those women obtained those services at Title X supported centers.<sup>85</sup> According to a Guttmacher Institute report released in 2010, over 17 million women between the ages of 13 and 44 were considered in need of publicly funded contraceptive services in 2008 due to their risk of having unintended pregnancies, their earning incomes below 250% of the federal poverty level, or not yet having personal incomes due to their youth.<sup>86</sup> This continually increasing demand for publicly funded contraceptive resources illustrates the crucial role that federally funded resources such as Title X serve. And because Title X programs are legally required not to charge patients with incomes below the federal poverty level, this dramatic increase in the number of female users suggests an increase in demand for contraceptive and family planning services among America's low-income women.<sup>87</sup> After all, one fourth of all women in the United States who obtain contraceptive services, as well as one half of poor women, use publicly funded health centers like those supported by Title X to meet their contraceptive and family planning needs.<sup>88</sup>

Some critics of increasing low-income women's access to reproductive health care may claim that the Title X Family Planning program already provides America's poorest women with contraceptive access, as evident in the millions of women it supports each year. However, the 2010 Affordable Care Act expands on the mission of this 40+ year-old federal grant program in

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<sup>84</sup> William D. Mosher et al., "Use of Contraception and Use of Family Planning Services in the United States: 1982-2002," *Centers for Disease Control and Prevention*, December 10, 2004, <http://www.cdc.gov/nchs/data/ad/ad350.pdf> (accessed March 17, 2013).

<sup>85</sup> Rachel Benson Gold et al., "Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System," *Guttmacher Institute*, <http://www.guttmacher.org/pubs/NextSteps.pdf> (accessed March 3, 2013).

<sup>86</sup> IBID.

<sup>87</sup> IBID.

<sup>88</sup> IBID.

order to enhance the federally funded resources available to low-income women. The three key functions of the Title X program include “training for family planning clinic personnel, data collection and family planning research, and information dissemination and community based education and outreach activities.”<sup>89</sup> These guidelines help individual communities better understand the family planning trends in their respective areas, but the priorities of this organization consist more of research and preparation, and less of action and correction. The key purposes of the Title X program do not include directly increasing access to reproductive health care. Thus, federal actions such as the 2010 Affordable Care Act are necessary to meet this growing need for access to reproductive health care among low-income women.

The Title X program has made a difference in the lives of millions of America’s poorest women. In fact, Title X-funded centers helped prevent 973,000 unintended pregnancies in 2008, and those pregnancies would have likely resulted in 432,600 unintended births and 406,200 abortions that year. Thus, Title X saved the US government 3.4 billion dollars in 2008 alone.<sup>90</sup> Title X facilities are not allowed to turn any woman away because of her inability to pay for treatments and services.<sup>91</sup> The fact that the unintended pregnancy rate in the United States continues to rise indicates that the federal government can do more to provide reproductive health care access to low-income women. The Affordable Care Act’s efforts exemplify just that.

This continuous rise in the unintended pregnancy rate, along with the increasing demand for publicly funded contraceptive resources, demonstrate the key role that the Affordable Care

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<sup>89</sup> “History of Title X,” *Office of Population Affairs*, <http://www.hhs.gov/opa/title-x-family-planning/> (accessed March 19, 2013).

<sup>90</sup> “Title X Fact Sheet,” *National Family Planning & Reproductive Health Association*, March 2012, <http://www.nationalfamilyplanning.org/document.doc?id=499> (accessed March 28, 2013).

<sup>91</sup> “Title X Family-Planning Services: Fast Facts,” *NARAL Pro-Choice America*, <http://www.prochoiceamerica.org/media/fact-sheets/birth-control-family-planning-title-x-fast-facts.pdf> (accessed March 27, 2013).

Act will play in expanding low-income women's access to reproductive health care beyond the resources available to them at Title X centers. But while ACA will allow 32 million Americans to become eligible for Medicaid, this "coverage does not automatically lead to access."<sup>92</sup>

Unfortunately, many Americans in need of health insurance, particularly low-income women, will still lack access to the health insurance provided under ACA over the next few years because of the predicted shortage in the public health care workforce.<sup>93</sup> Because of this shortage, programs like Title X will continue to serve as safety-nets for those who do not immediately gain access to ACA's health insurance coverage.

Thus, the Affordable Care Act's expanding low-income women's access to preventive services was not designed to replace the Title X Family Planning Program. Rather, ACA provides low-income women with another federally funded health care resource, which can enhance the overall effectiveness of the Title X Family Planning Program. Until the demand for public health care providers can be met to cover this newly insured population created by ACA, Title X will continue to provide low-income women with much needed access to reproductive health care.

## **Conclusion**

Without access to reproductive education, counseling, and contraception, America's low-income women and their children are in jeopardy. Employers, regardless of their religious beliefs, need to realize that providing access to contraceptive measures is both a means to reducing abortion rates and a critical component of their female employees' overall health and

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<sup>92</sup> "Policy Brief: Title X Plays a Critical Role in Preventing Unplanned Pregnancy," *The National Campaign*, [http://www.thenationalcampaign.org/resources/pdf/Briefly\\_PolicyBrief\\_TitleX.pdf](http://www.thenationalcampaign.org/resources/pdf/Briefly_PolicyBrief_TitleX.pdf). (accessed April 9, 2013).

<sup>93</sup> IBID.

well-being. As the Center for American Progress argued, “insurance coverage that denies access to these preventive services denies young women a basic pillar of their health care that [...] could compromise their health in the long term.”<sup>94</sup> By eliminating the cost sharing of preventive services like contraception, the Affordable Care Act allows low-income women to do more than plan their pregnancies. This increased access to reproductive health care expands the health and economic opportunities available to low-income women and their children, as well as reduces their costs to American society.

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<sup>94</sup> Jessica Arons, Lucy Panza, and Lindsay Rosenthal, “Young Women and Reproductive Health Care,” *Center for American Progress*, July 30, 2012, <http://www.americanprogress.org/issues/women/news/2012/07/30/11863/young-women-and-reproductive-health-care/> (accessed March 28, 2013).

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