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Breaking the Cycle of Poverty:

Expanding Access to Family Planning

White Paper by
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EXECUTIVE SUMMARY

Poverty shapes the lives of an increasing number of American women and their families and has many consequences, including high rates of unintended pregnancy. Conservatives, eager to further dismantle federal programs and defeat the new Affordable Care Act (ACA), have recently rekindled the idea that marriage promotion will reverse rising rates of poverty, unintended pregnancy, and single parenthood. To the contrary, addressing the root causes of poverty requires multiple interventions and far more generous government programs across a range of issues, particularly the expansion of reproductive health and family planning information, care, and services. This paper reviews the recent literature on women's poverty and health and argues that accessible and high quality family planning services for poor women remain an essential component of poverty reduction. It also looks back at the history of policy debates over this question in the hope of finding a path toward renewed bi-partisan consensus.

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KEY ARGUMENTS

- Family planning is a fundamental right of women and the foundation of human security.
- Single women in poverty head a growing percentage of U. S. households. Addressing their needs requires multiple policy interventions, but none can work if women are denied the agency to make – and act on – well-informed reproductive health decisions.
- U.S. subsidized family planning programs meet only 54 percent of national need. The ACA will help bridge the gap, although its promise is threatened by legal challenges to the contraceptive mandate. Women deserve insurance coverage for the contraceptive method of their choice, without qualification.
- Many low-income women will fall through insurance gaps. Every state should expand Medicaid. The federal government should lift Medicaid's five-year eligibility requirement for documented immigrants and increase Title X funding to address increased demand for services.
- We can learn from history. Research since the 1970 adoption of Title X illustrates that access to improved family planning methods promotes responsible decision-making and reduces unwanted pregnancy and abortion. By contrast, abstinence-until marriage and marriage promotion programs advanced by conservatives have failed and been discredited.

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INTRODUCTION

One in seven Americans today – 46.5 million people in the richest country in the world – live in poverty. For a family of three that means an annual income of under $19,530, and today, a family of three is fast becoming the typical constellation of the impoverished. Women as sole breadwinners head a growing percentage of poor households, and half of all U.S. children in poverty live with a single mother. These women – many of them young and with little education, and many also women of color and/or immigrants – bear a disproportionate burden of what remains the country's greatest economic, social and political challenge (U.S. Census Bureau).[1]

It wasn't supposed to be this way. Over the past half-century, American women have made many advances in education and employment. Assumptions about our abilities and ambitions have been transformed, along with mainstream views of marriage and family obligations. Today women comprise nearly half the workforce, typically work through the life cycle, and are the sole or primary wage earners in over 40 percent of all U.S. households (Kim 2013). The benefits of this cultural shift are palpable in the upper and middle reaches of our society where opportunities have opened up to women, both single and coupled, in business, professional life and the public sector.[2]

For low-income women making it on their own, however, life has become increasingly difficult. Since the recession of 2008, absolute poverty rates overall, and especially among single women with families, are trending upward, even as the Obama administration argues reasonably enough that given the enormity of the downturn, things could have been much worse (DeNavas-Walt, Proctor, and Smith 2013). Economic recovery in the private sector has been slow. Misguided austerity policies and a frayed social safety net have prevented adequate public sector job creation and cut income enhancements. Wage stagnation for most workers has combined with the dogged persistence of unequal pay and sex segregation in many sectors to hit working women especially hard.

The federal government has attempted to address the issues of low-income women before. The United States in 1996 replaced Aid for Families with Dependent Children (AFDC), the major cash welfare program that had assisted low-income families since the New Deal, with the deliberately and provocatively named "Personal Responsibility and Economic Opportunity Act," which included a state-level block grant called Temporary Assistance to Needy Families (TANF). Cash entitlements were limited in duration, and poor women, long permitted to stay home and care for their children, were made to work instead. Women were encouraged to access employment training programs, meant to expand their earnings, and also to take advantage of family income supplements such as food stamps, free health through Medicaid, and work-related tax credits. Each state developed its own guidelines, and given variations in outreach and generosity of local programs, some were more successful than others at transitioning families from welfare (McKernan and Ratcliffe 2006, Nathan and Gais 2001).[3]

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[1] *Current Population Survey (CPS), 2013 Annual Social and Economic Supplement (ASEC),* http://www.census.gov/hhes/www/poverty/about/overview/

[2] It is important to note that while professional opportunities for women have certainly expanded over the past half-century, achieving economic security is out of reach for many because of a lack of policies mandating pay equity and enabling women to achieve greater work-family balance. Indeed, outside of a handful of progressive states, few policies exist to help employed and under-employed women better manage the burden of balancing work and family obligations through mandatory paid sick days, flexible work or paid leave policies, and affordable childcare (Covert 2012).

[3] In the best situations, states provided expanded services and assistance as promised to help transition families from welfare. However, because the legislation contained insufficient enforcement mechanisms, other states, especially where conservatives still opposed the program on ideological grounds and resisted paying the local share of its costs, simply left poor families without services of any kind.

The extent to which welfare reform improved the economic circumstances of poor families is the subject of much debate. Some research claims success on the basis of reduced welfare rolls and data demonstrating a short-term 40 percent decrease in poverty levels overall, when the benefits of TANF supplements were valued and added into income calculations (Gabe 2011, Haskins 2012). Early research also argued that the steady but small reductions in the country's high teen pregnancy rates of this era were a result of the new work requirements under TANF.

Subsequent studies, however, have shown that many poor women struggled even more under TANF. There were a number of unintended consequences to the program, with the numbers in extreme poverty actually increasing as access to public assistance decreased (Peterson 2012, Lyter et al. 2002). The work requirement made it difficult for struggling young mothers to attend college and enrollment in higher education declined, further compromising long-term opportunities. There was confusion around health care. Intended expansion of Medicaid benefits to women with jobs did not always materialize, so many families lost coverage they had relied on, before alternatives such as the State Children's Health Insurance Program (SCHIP) became available (Peterson 2012, Hildebrandt and Stevens 2009). Recent analyses of teen pregnancy now also attribute the gradual declines after 1996 to larger economic and social circumstances, not to specific changes in welfare policies (Kearney and Levine 2014). While the situation of a large number of women and their families improved briefly, therefore, poverty levels began to rise again in 2006, and then the recession of 2008 occurred, reversing previous employment gains and driving poverty levels further up.

The 2008 recession has affected both men and women, but women are bearing a disproportionate burden of the sluggish recovery. While 1.6 million jobs were added to the private sector over the course of the recovery, women gained just one out of seven of those new jobs (Abramovitz 2012). With the federal government essentially paralyzed by deep partisan divides over economic and social policy, women's economic circumstances are unlikely to improve and may worsen in the years to come.

In recent months, conservative pundits and policymakers have seized on the 50th anniversary of Lyndon B. Johnson's War on Poverty to revisit the tired narrative that families headed by single mothers are to blame for America's rising tide of poverty and inequality, and not the other way around. Marriage, they claim, is the simple solution to the social and economic problems that plague our nation (Whitaker 2014).[4] They look to the growth in single-parent families and poverty rates to make their case: the proportion of births to unmarried women has, indeed, grown by 46 percent over the past 20 years, and today nearly half of children living in single-mother homes are living in poverty, compared with 11 percent of children living with two married parents (Williams 2014). Yet studies have shown that marriage advocacy programs do little to improve the economic circumstances of poor women, and that poverty itself drives a decrease in marriage rates, not, as is argued, the other way around (Furstenberg 2007, Williams 2014).[5]

"Family formation" was itself a stated goal of the 1996 welfare reform, but despite many incentives, marriage rates among low-income mothers have continued to decline (Furstenberg 2007, Williams 2014). TANF went to

[4] Unintended pregnancy and single parenthood were initially thrust into the spotlight as a topic of social concern in 1965 when Daniel Patrick Moynihan issued a report that framed the increasing rates of non-marital childbearing among black women, particularly young black women, as a social problem demanding immediate attention (Moynihan 1965). Moynihan's report built on – and perpetuated – the historic narrative that blames vicious cycles of poverty on declining rates of marriage and increasing rates of out-of wedlock birth, particularly among poor women, women of color, and immigrant women.

[5] Williams (2014) shows that marriage is unlikely to improve the lives of low-income single mothers and that the conditions of poverty actually deter women from entering into marriage. Williams shows that marriage among single mothers may actually have negative consequences. More than 60 percent of single mothers who married were divorced between the ages of 35 and 44, and those mothers were economically worse off than single mothers who never married. Additionally, the research indicates there are few advantages for the majority of adolescents born to a single mother who later married. The study proposes that one of the most promising approaches to improving the circumstances of low-income women is to reduce unintended and mistimed births.

great lengths to provide incentives for marriage by granting states more flexibility to prioritize two-parent families over single mothers, and by establishing an "illegitimacy bonus" that rewarded states with the largest reductions in non-marital birth ratios and abortion rates. Most egregiously, it created Title V, a funding stream specifically for abstinence-only sexuality education, quickly demonstrated as ineffective, and then shut down in many states, before it was finally ended by the Obama administration.

Nevertheless, a newly invigorated generation of conservative legislators again seeks to control women's sexuality through discredited and harmful policies. Their marriage arguments are also buttressing unprecedented attacks on women's access to primary healthcare – attacks that are closing existing family planning clinics across the country and seeking to dismantle the Affordable Care Act's (ACA) provisions guaranteeing expanded access to care. In March 2014, the Supreme Court heard cases involving two companies – Hobby Lobby and Conestoga Wood – both challenging the ACA's contraceptive mandate on the dubious grounds that it violates the religious liberty of private companies. The outcome of these cases will determine the mandate's fate.

Underlying this opposition is the dogged belief that programs providing sex education, birth control, and general reproductive health care exacerbate social problems by promoting promiscuity and, in turn, unintended pregnancies. These myths have been debunked many times by research using longitudinal, population-based data that demonstrates exactly the opposite outcomes (Kirby 2007, Trenholm et al. 2008, Secura 2014). Access to reliable contraception reduces unwanted pregnancies and allows women to balance work and family and to create more secure lives for themselves and their families. Yet still the counter narrative persists, strategically diverting attention from the larger economic factors that shape poverty and inequality, and disregarding the critical importance of government programs to address their root causes.

This paper argues that because one of the critical factors shaping the lives of low-income women remains a significant lack of affordable and accessible family planning options, the United States needs expanded public assistance for contraception and reproductive health. Current U.S. family planning programs only meet 54 percent of national need (Guttmacher 2014). The Affordable Care Act (ACA) will go a long way to bridge the existing gap by mandating coverage of reproductive health services, including family planning. This will expand care to many women for whom it has previously been out of reach. Even then, many women will fall through insurance gaps - and will continue to rely on services provided by Title X, the country's longstanding dedicated family planning program. (Flynn 2013 "Title X", Gold 2013).[6]

A more serious commitment to free and comprehensive reproductive healthcare is a critical step in meeting the needs of low-income women. The majority of women in a recent Guttmacher Institute study state that birth control enables them to support themselves financially (56 percent), complete their education (51 percent), and get or keep a job (50 percent) (Frost and Lindberg 2013). Additional studies confirm that providing family planning services at no cost, including long-acting methods and emergency contraception, results in more effective contraceptive use, decreased rates of unintended pregnancy by nearly 30 percent, and significant declines in abortion rates (Durkin 2013, Hartocollis 2012, Jones and Jerman 2014).

International human rights instruments define reproductive freedom and the provision of voluntary family planning by the state as a fundamental human right of women and as the foundation of basic human security. Multiple interventions are required to alleviate poverty, but none can work if women are denied the agency to make – and act on – well-informed decisions about their own bodies.

All women must have the freedom and ability to access the family planning method of their choice. As the National Latina Institute for Reproductive Health (NLIRH) has said, policies that provide women with the skills

[6] In 2010, five of the 19 states that had budget line items specifically for family planning made disproportionate cuts relative to other programs.

and resources to delay or prevent pregnancy must also "speak to their right to a healthy pregnancy, to have an abortion, to parent with dignity, to an education and well-paid career, and their human desires, dreams, and experiences of forming relationships and families" (Fuentes, Bayetti Flores, and Gonzalez-Rojas 2010).

This paper describes the reproductive health challenges experienced by poor women in this country. We argue that the ACA can transform women's health and reproductive outcomes – and also improve their economic circumstances – by guaranteeing comprehensive women's healthcare, including easy and no-cost access to a wide range of reliable and long-acting contraceptive options. We also describe the important role that existing federal programs such as Medicaid and Title X (the only federal program solely focused on family planning) must continue to play in enabling low-income women to access health care. We describe current challenges to those programs and to the ACA, challenges that disrupt their core public health, social welfare, and economic objectives, and dilute their effectiveness, with the impact on single women struggling to support their families sure to be most devastating.

The paper concludes by investigating the history of public policy debates over family planning to ask if this history suggests a way out of our current political impasse. Fifty years ago, after decades of prior conflict over the issue, a bi-partisan consensus developed around the economic and social benefits of family planning. It produced the public funding mechanisms for contraception through Medicaid subsidies and the Title X program that are today, along with the ACA, so violently contested.

What can we learn from the past to convince our opponents that expanding access to sexual and reproductive health information and services – particularly family planning – does not promote irresponsible behavior? Guaranteeing all women the right to experience their sexuality free of consequence – just as men have always done – is not a threat to the cohesion of families and communities. Quite the opposite, it is a sure way to increase the likelihood of responsible, safe, and respectful behavior in both initial and subsequent sexual activity (Kirby 2008), and to help women balance work and family obligations – just as the experiences and positive outcomes of more economically privileged women, with better access to sex education and contraception, now typically demonstrate, whether they are single or in coupled arrangements (Kaufman 2006).

The paper makes four specific policy recommendations to improve the lives and health of low-income women and their families:

- The contraceptive mandate must continue to be a cornerstone of the ACA, and must be defended vigorously against all political and legal attacks.
- Medicaid should be expanded in all states so that all low-income women will be able to access care.
- The current wait limit that prevents documented immigrants from enrolling in Medicaid until they have resided in the United States for five years should be removed.
- Title X funding must be increased so that the nation's sole program dedicated exclusively to family planning can effectively deliver reproductive health care to the ranks of low-income women who will continue to seek care and services at those publicly funded facilities.

LINKS BETWEEN POVERTY AND REPRODUCTIVE HEALTH

Substantial progress has been made in recent years in the development of contraceptive technologies that allow women to better control their health and reproductive lives. Access has also been improved. These factors have contributed to a dramatic decrease in total U.S. fertility rates during the past half-century, which have in turn helped change the status of middle-class women and the circumstances of their families. Still, unmet need for family planning persists, especially among poor women.

Poor women overall experience higher rates of chronic disease, maternal mortality, and unintended pregnancy and have a lower life expectancy than women with higher incomes (Amnesty 2010). Once age, race, and immigrant status are also introduced as factors, along with income, these health disparities become even worse.

Women of color, who have poverty rates more than double those of white women, experience the most significant reproductive health problems (Macartney 2013). Rates of human papillomavirus (HPV) are much higher among black women and Latinas, and their mortality rates from cervical cancer are double those of white women. Rates of chlamydia and gonorrhea among black women are 19 times higher than those of white women, and women of color represent 25 percent of the U.S. female population but account for 80 percent of reported female HIV/AIDS diagnoses (Guerra 2013).[7] Black women have a maternal mortality rate three to four times the rate of white women, a discrepancy that actually holds constant across income levels (CRR "Disparities"). They also have the highest rates of premature birth and are more likely to have infants with low or very low birth weights. Infants born to black women are still, tragically, more than 2.4 times more likely than those born to white women to die in their first year of life (Guerra 2013, Jackson 2013).

All women in poverty in the U.S. are also much more likely to experience an unplanned pregnancy, often in adolescence or shortly thereafter, before educational achievement, work, and family relationships are secure. According to one recent study, the rate of unintended pregnancy among poor women is more than five times that of women with incomes at least 200 percent of the federal poverty level (137 compared to 26 per 1,000) (Guttmacher "Unintended"). The ability of women to control their pregnancies contributes to the increasing divide in opportunities, circumstances, and health outcomes between women of means and those without.

Poor women of color experience even higher rates of unintended pregnancy and abortion than white women. Low-income black women are three times as likely as low-income white women – and low-income Latinas nearly twice as likely – to have an unintended pregnancy. Half of all pregnancies in the U.S. remain unplanned or mistimed, with the great majority – more than 70 percent – now experienced by unmarried women, most often poor and young, and disproportionately women of color (National Campaign 2007). One study found that 69 percent of African American women and 56 percent of Hispanic women reported their pregnancies as unintended, compared to 42 percent of white women (Finer and Zola 2014).[8] Almost half of all unintended pregnancies in the U.S. end in abortion. African American women, who are three times as likely as white women to experience an unintended pregnancy, are also three times as likely as white women to obtain abortion services.

Unintended pregnancies also have larger health implications. According to the Centers for Disease Control and Prevention (CDC), women who report unintended pregnancies are more likely to develop complications and face worse outcomes themselves and for their infants. They often receive inadequate prenatal care, and the care they do receive begins late in pregnancy. Research has shown that pregnancies that occur in rapid succession pose additional risks for both mother and child. For example, when a woman becomes pregnant less than six months after giving birth, the risk of maternal death may be as much as 2.5 times higher (Amnesty 2010).

Racial and income disparities are particularly pronounced with respect to teen pregnancy. While the rate of sexual activity is far lower among the U.S. teen population than among adults, the unintended pregnancy rate among sexually active teens is more than twice the rate of the general population (Guttmacher "Unintended"). Teen pregnancy rates have declined in recent decades, and particularly so over the past five years, during which a notable increase in the rate of decline – from 2.5 to 7.5 percent per year – has been reported (Kearney and

[7] African American women represent 65 percent of new AIDS diagnoses among U.S. women (Guerra 2011).

[8] The unintended pregnancy rate (number of unintended births per 1,000 women) is markedly higher for women of color, with rates for African American and Hispanic women at 92 and 79 per 1,000, respectively, compared to 38 per 1,000 among white women (The Guttmacher Institute "Unintended").

Levine 2014). Recent research from the Brookings Institution argues that these trends, which mirror declines in other developed countries, are the result of expanded access to new family planning technologies, information and care, and greater educational opportunities for women. The study argues that for young women who want to prevent pregnancy, greater access to contraception – particularly long-acting methods – will continue to drive down the rate of unintended pregnancy. It also acknowledges, however, that some economically disadvantaged young women remain ambivalent about pregnancy and do not actively try to prevent it. For these women, it will also be necessary to improve education and career options to broaden their choices as they enter adulthood (Kearney and Levine 2014).

Despite these significant improvements, the U.S. teen pregnancy rate is still considerably higher than in any other developed country, where rates are generally 5 to 10 births per 1,000, compared to the current U.S. rate of 29.4. Racial disparities are also especially pronounced here in relation to teen pregnancy. As of 2011, teen birth rates for white women hovered around 21.8 per 1,000, while the rates for Hispanic, Black, and Native American teens were at least twice that (49.4, 47.4, and 36.2 per 1,000, respectively) (Hamilton, Martin, and Ventura 2012).[9] Two-thirds of families begun by young unmarried mothers are poor and approximately one-quarter of teen mothers rely on some form of welfare assistance within three years of the child's birth (Guttmacher "Unintended").

Many factors drive these significant health and reproductive disparities. One is the high rate of uninsured in the United States, which leads to a lack of access to reproductive health care including family planning. As of 2008, women of color were more likely to be uninsured than white women: approximately one-third of Latinas (36 percent) and Native Americans (33 percent), and 22 percent of Black women were uninsured, compared to 13 percent of the white population. More than 44 percent of immigrants – and 60 percent of adult undocumented immigrants – living in the United States were uninsured (Amnesty 2010).

The ACA will significantly bridge the gap, but still leave many women with unmet need for family planning and reproductive health services. Even with significant subsidies of contraception through Medicaid and Title X the costs of contraception and the hurdles to easy access may still be too high (Cuellar, Simmons, and Finegold 2012).[10]

THE AFFORDABLE CARE ACT: IMPROVING WOMEN'S LIVES

In championing the ACA, President Obama acknowledged the detrimental impact that lack of access to quality, affordable health care has on women's lives. The ACA will make health coverage affordable to millions of women for the first time and as such will serve as a critical instrument to improve public health and advance economic opportunity. The law mandates coverage of a wide range of reproductive health services, prohibits gender discrimination, and extends parental insurance coverage for millions of young people up to the age of 26, a provision that has already extended coverage to 7.8 million young adults who would otherwise be uninsured (The Commonwealth Fund 2013).

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[9] Pregnancy rates among these populations were comparable: Black and Hispanic women have the highest teen pregnancy rates (117 and 107 per 1,000 women aged 15–19, respectively); whites have the lowest rate (43 per 1,000) (Guttmacher "Teen Sexual and Reproductive Health").

[10] The Public Health Service Act (PHSA) was originally enacted in 1944 under President Roosevelt. As part of sweeping changes ushered in the post-World War II and New Deal era, it modernized and reorganized the nearly 150-year old Public Health Service (PHS) and drastically expanded the government's role in public health. It turned the PHS into a department focused on advancing public health by building health care facilities, training health professionals, and subsidizing biomedical research at private institutions. Family planning was not included in the original PHSA because of religious objections and because it remained without full legal protection. Some regarded the PHSA as FDR's attempt to lay a foundation for national health insurance, a goal that was hotly debated in the early '40s and was never realized. Title X is just one of the many amendments made to the PHSA since its original passage. The ACA is another such amendment.

The ACA is groundbreaking in its recognition of the importance of family planning and reproductive health care in women's lives. The law's "contraceptive mandate" requires that all private insurers cover without cost-sharing all FDA-approved contraceptive methods, making the most desirable and effective contraceptive methods, such as long-acting reversible methods (LARCs) like the IUD and implant, accessible to many women for the first time. It also requires coverage of a broad range of preventive health services that will vastly improve women's sexual and reproductive health.[11] Additionally, it prohibits insurance companies from using pre-existing conditions as a reason to deny care, or charging women higher premiums than men, signifying for the first time that federal law prohibits sex discrimination in health care (National Women's Law Center 2013).

Expanded coverage for such a comprehensive list of health services is critical to women's economic security. A study by The Commonwealth Fund finds that the current economic environment leaves women particularly vulnerable to high health care costs, because they have higher out-of-pocket medical costs, and earn less than men do, but simultaneously require more health care services during their reproductive years. Women are "more likely to forgo needed care because of cost and to have problems paying their medical bills, accrue medical debt, or both. Too often, problems with medical bills and medical debt force women to make difficult tradeoffs between health care, savings, credit card debt, mortgages, and basic necessities" (Rustgi 2009).

Expanding access, improving outcomes

The ACA rests on three programmatic pillars: an expansion of Medicaid that represents the largest growth in coverage since the program's creation in the 1960s; tax subsidies that will enable individuals to purchase insurance through the new, competitive state health exchanges; and large-scale investments in a national network of community health centers intended to serve as a critical foundation for the nation's health safety net. These programs together are meant to enable women of varying economic circumstances to access reproductive health care and services and effectively plan the timing and size of their families.

Medicaid expansion

Under the ACA, the federal government is obligated to provide funding for each state to expand Medicaid to all individuals who fall below 138 percent of the federal poverty level ($15,415 for an individual or $26,344 for a family of three) (Kaiser 2012 "Medicaid Expansion"). The new law enables states to expand Medicaid eligibility for family planning services to individuals who did not qualify previously, and it requires the coverage of adolescents and men who were exempt under prior rules. It vastly simplifies and improves the previous system, in which states had to navigate complex processes to obtain a waiver from the federal Medicaid rules to establish these expanded family planning programs.

The ACA was initially intended as a path to insurance for all Americans, partly through its original requirement that every state must accept funding for Medicaid expansion. However, last year the Supreme Court ruled that requiring states to participate in the expansion is unconstitutionally coercive and gave them the ability to opt out (Kaiser 2012 "Supreme Court"). Today, 21 states have rejected funding. However, states that do participate in Medicaid expansion will be reimbursed for 100 percent of the program's cost during the first three years, and then for a minimum of 90 percent of the cost in the years to follow.

There are also millions of women whose income levels would qualify them for Medicaid, were it not for their immigration status. Existing federal law requires lawfully present immigrants to reside in the United States for five years before becoming eligible for Medicaid. This requirement leaves them uninsured and vulnerable in the meantime. Additionally, 7.6 million of the approximately 11 million undocumented immigrants are uninsured, many of them living in Southern states that have refused funding for Medicaid expansion. The majority of these

[11] The ACA mandates coverage for the following services: Pap smears, testing and counseling for sexually transmitted infections, HPV vaccines, preconception and prenatal care visits, postpartum counseling and education, and breastfeeding support, along with one comprehensive "well-woman" visit a year (Cuellar 2012; Flynn 2013; HRSA "Women's Preventative Service"; Sonfield 2012).

individuals – 4.1 million – have incomes that would qualify them for Medicaid expansion. Nearly all undocumented immigrants who are uninsured have incomes too low to qualify for state subsidies (Capps 2013).

Health exchanges
A second pillar of the ACA is the establishment of health exchanges, also known as marketplaces. Through these exchanges, individuals who neither qualify for Medicaid nor have employer-based coverage can use tax subsidies to purchase private insurance. Ultimately, individuals and small businesses will be able to choose among plans of varying costs and coverage benefits in a competitive online marketplace. Those who are currently uninsured and opt not to purchase health insurance through the exchanges will face a tax penalty.

Investment in Community Health Centers (CHCs)
A third pillar of the ACA is an expansion of CHCs, long a major foundation of the U.S. health care system. In 2011, these public providers served more than 20 million patients nationwide. 60 percent of these patients were women, and 25 percent (4 million) were women of childbearing age. (Wood, et al. 2013). As part of the ACA, the federal government will invest approximately $11 billion over the next five years to increase the capacity of CHC's and help meet the needs of the nation's newly insured individuals (U.S. Department of Health and Human Services 2012).

The health and economic well-being of poor women and their families rests on maintaining the viability of all three programs that comprise the ACA.

Bridging a gap at a critical time
Expanding access to family planning and reproductive health care is critical to women's economic security. Until recently, the high costs of reliable family planning placed it out of reach for many American women. According to the Guttmacher Institute, current family planning programs are only providing services to 54 percent of the individuals who need and want them. For those without access to subsidized family planning, the high cost of care puts it out of reach for most women. Research from the National Women's Law Center has shown that it is not uncommon for contraception to cost women more than $500 a year, a prohibitive fee for those living at or below the poverty level and already struggling to make ends meet (NWLC 2013).

The high cost of contraception becomes a particularly significant barrier to family planning in times of economic instability. A 2009 study by the Guttmacher Institute on the effects of the 2008 economic downturn on contraceptive use showed that 8 percent of women dispensed with birth control all together, while 18 percent used it inconsistently as a way to save money, putting themselves at greater risk of unintended pregnancy. At the same time, data suggests that economic uncertainty may have motivated women and couples to postpone, or even forgo, childbearing. The Guttmacher Institute recently reported:

> "Trends in unemployment between 2007-2009 were accompanied by a drop in the fertility rate and, more specifically, that states that experienced greater economic distress had larger birthrate declines during this period. These findings are substantiated by a national survey of women conducted in 2009, which found that 44 percent wanted to delay or limit childbearing because of the economy; this sentiment was more common among women with lower incomes (52 percent)" (Jones and Jerman 2014).

Additional research demonstrates that expanded access to family planning improves contraceptive use and contributes to declines in unintended pregnancy and abortion. A breakthrough clinical study of a large cohort of women in Missouri, for example, shows the significant benefit that completely free family planning can have on individual women and on the country as a whole. Washington University's Contraceptive CHOICE Project (2012) enrolled about 10,000 women ages 14 to 45 (with a mean age of 25) identified as being at risk of unintended pregnancy and desiring contraception. Each participant was given the reversible contraceptive method of her choice, at no cost, for two or three years.

Contraceptive efficacy among participants in the study increased significantly, and abortion rates fell to less than half the regional and national rates, even though study participants were poorer and less educated, and therefore considered at considerably greater risk of unwanted pregnancy than the overall population. The impact on the rate of births among teens was the most pronounced, with pregnancies falling dramatically to a rate of only 6.3 per 1,000, compared to a national average of 34.3 per 1,000 (Flynn 2013 "Title X").

The study also found that 75 percent of women enrolled in the CHOICE study opted for long-acting reversible methods such as the IUD or hormonal implant – methods that are statistically far more effective than condoms and birth control pills, which require daily self-administration. Today, most American women use the less effective methods because LARCs have much higher upfront costs, which before the ACA were rarely reimbursed even for those with contraceptive coverage. The CHOICE study confirms the potentially transformative impact of the ACA's provision of no-cost coverage for all FDA-approved methods of contraception.

Similar programs in other cities suggest the same beneficial outcomes of providing no-cost contraceptive care. An initiative in New York City – where each year more than 7,000 young women become pregnant by the age of 17 – has expanded young women's access to family planning and emergency contraception through school-based clinics. Such programs have contributed to a 27 percent drop in teen pregnancy in New York City over the past decade. Perhaps most interesting is that while rates of contraceptive use have increased, sexual activity among teens has decreased, illustrating the benefits of teaching young people about sex and the associated risks (Durkin 2013; Hartocollis 2012).

Moreover, a March 2014 study by the Guttmacher Institute indicates that increased and improved use of contraception, particularly LARCs, may have also contributed to a decrease in abortion rates. The report observes that the U.S. abortion rate dropped 13 percent between 2008 and 2011 and is now at its lowest point since any time before Roe v. Wade. It shows a parallel uptake during this period of LARC methods among contraceptive users, particularly those who use publicly-funded clinics. "LARC use among women accessing publicly funded contraceptive services increased from 4 percent to 11 percent in this period, and reliance on condoms or nonprescription methods fell from 25 percent to 17 percent" (Jones and Jerman 2014). Underscoring the complexity of establishing cause and effect, however, the study also points out that a precarious economy may have also played a role in decreasing the abortion rate and reiterates the importance of ensuring women's access to family planning during times of economic instability.

Providing no-cost contraception – and giving women the option to utilize long-acting, high efficacy methods previously available only to a minority of women who paid out of pocket or through insurance coverage – should reduce unwanted pregnancy among poor women. Upholding the ACA's contraceptive mandate, expanding Medicaid in all states, and strengthening Title X and the nation's network of family planning providers will enable the benefits seen in the above-mentioned studies to be extended to many more American women and their families.

PUBLIC FAMILY PLANNING PROGRAMS: A CONTINUED FOUNDATION OF THE U.S. HEALTH SYSTEM

For the past four decades, Medicaid and Title X have built an essential infrastructure for providing preventive health care to millions of low-income women. Both remain necessary for the immediate implementation and long-term success of the ACA, and to improve women's health and economic outcomes in the years to come. The two programs have complementary functions: Title X provides medical services and "wrap-around funding" that enables clinics to keep their doors open, shelves stocked, and staff trained and gainfully employed. At the same time, Medicaid operates as an insurance plan that pays for qualified low-income patients to receive care at those facilities. Both of these programs play a critical role in ensuring quality, affordable health services and maintaining a high standard of reproductive health care on which low-income women can rely.

Medicaid

Medicaid plays an important role in enabling low-income American women to access family planning services and has proved to be highly effective in terms of health and financial outcomes. Seventy percent of Medicaid's enrollees are women, and the program covers four out of 10 births in the United States annually, with the federal government compensating states for 90 percent of the costs of all pregnancy-related programs (Sonfield, Frost, and Gold 2011). Medicaid family planning programs result in improved contraceptive use, fewer unintended pregnancies, and longer intervals between births. Every $1.00 spent on publicly funded family planning saves an estimated $5.68 in Medicaid expenditures (Frost, Zolna and Frohwirth 2013).

Medicaid enrollees are not responsible for deductibles and co-pays and by law they have the freedom to visit providers of their own choosing, even if those providers are not a part of their network (NFPRHA "Medicaid"). Some states have attempted to challenge this requirement by excluding Planned Parenthood and other providers that also provide abortion. Last year, for example, Texas forfeited all of its Medicaid family planning funds just to prevent Planned Parenthood from receiving any part of them. Other states have attempted to disqualify family planning providers like Planned Parenthood, but Texas is the only one so far willing to forfeit all federal funding to achieve its goal, much to the detriment of low-income women there (Flynn 2013 "Texas").

Title X

Title X funding supports a network of nearly 7,000 community-based family planning clinics and provides health services to 4.76 million individuals (Frost, Zolna and Frohwirth 2013). Seventy-one percent of these clients have incomes below the poverty line, and 21 percent have incomes between 100 percent and 250 percent of the federal poverty level. In 2012, 64 percent of Title X clients were uninsured (Fowler 2013).

Title X is a highly effective public health program. Research conducted over two decades demonstrates that it prevented an estimated 20 million unintended pregnancies and nine million abortions and helped to prevent 5.5 million adolescent pregnancies (Gold 2001). Between 1980 and 2000, Title X-funded health centers also provided 54.4 million breast exams and 57.3 million Pap tests, resulting in the early detection of as many as 55,000 cases of invasive cervical cancer (Gold 2001). Family planning services at Title X health centers prevent an estimated 996,000 unintended pregnancies annually, 200,000 among teens (HRSA 2013). There are significant economic benefits to the program as well. By preventing costlier obligations, Title X supported clinics accounted for an estimated $3.4 billion in government savings in 2008 alone (Frost, Finer, and Tapales 2008).

Title X funding enables clinics to serve uninsured family planning clients with the contraceptive method of their choice. Title X clinics are able to devote time and expertise to specific populations, including eligible legal immigrants and adolescents (Gold 2012). The program has also served as an important standard bearer for family planning care nationwide by requiring the clinics it funds to meet a comprehensive set of requirements.

The demand on Title X clinics will only increase as the ACA is implemented. Many women who receive coverage through the ACA will continue to rely on public providers – particularly those funded through Title X – for family planning and reproductive health care. New research from Massachusetts – a state whose health reform served as a model for the ACA – indicates a continued need for safety net providers even when the rates of uninsured drastically decrease. As of 2011, nearly 97 percent of Massachusetts' residents are insured. Between 2005 and 2012, the percentage of Title X clients who were uninsured declined from 59 percent to 36 percent, but client volume only decreased by 10 percent during that same time period (Carter et al. 2014). The results of this study indicate that publicly funded providers will continue to be the providers of choice for many women. Indeed, other data from Massachusetts indicates that patients continue to rely on safety net providers because they prefer the quality of care offered there. These patients reported using CHCs because they were convenient (79.3 percent) and affordable (73.8 percent). Only 25.2 percent reported doing so because they experienced problems getting appointments elsewhere (Ku, et al. 2011).

As the above data shows, even newly insured women will continue to rely on publicly funded clinics for reproductive health care. Women circumvent their insurance plans for a variety of reasons, including confidentiality concerns related to intimate partner violence or dissenting religious convictions of employers, family, and partners.

Many CHCs receive Title X funding, and those that do have a greater capacity to provide comprehensive family planning services to women from a broad range of populations. As such, the program will strengthen the provider network serving the ranks of people newly insured under the ACA. According to a George Washington University study, Title X-funded CHCs have "higher proportions of patients who are uninsured, Medicaid eligible, adolescents, and women of childbearing age, and a lower proportion of non-Hispanic white patients, suggesting that their services are of particular importance to minority women" (Wood, Susan et al. 2013). These clinics also offer a greater range of contraceptive methods, including emergency contraception and LARCs (Flynn 2013 "Title X"). They also maintain more staff specially trained to serve a greater number of population groups, specifically immigrants and adolescents. Meeting the needs of adolescents is a particular hallmark of Title X funding, and 91 percent of clinics retain staff that are specially trained in addressing the needs of this younger population. As the Guttmacher Institute has argued:

> Title X funding enables a clinic to go beyond the provision of bare-bones clinical care to craft a multi-faceted effort in which clinicians and counselors with specialized training can take extra time with clients needing extra effort, and resources are invested in community outreach to identify the agency as a source of high-quality, culturally appropriate, affordable and confidential care (Gold 2012).

Despite its significant and unique contributions to individual American women and U.S. public health more broadly, Title X is perennially underfunded. In the years ahead it will play an increasingly important role in providing care to the newly insured, those who remain without coverage, and those who choose to continue to visit these providers for a variety of reasons. The National Family Planning and Reproductive Health Association estimates that Title X is currently meeting only 35 percent of the population in need, and that functioning at full capacity would require approximately $800 million, a big leap from the $327.4 million appropriated for fiscal year 2014 (Coleman 2013).

FAMILY PLANNING UNDER ATTACK

On October 1, 2013, Congressional Republicans, in thrall to Tea Party conservatives in their ranks, shut down the federal government to protest President Obama's health care policies. It was the third such threat (though the first successful one) in only two years, motivated by conservative disdain for the contraceptive mandate, in general, and for Planned Parenthood as an institution, in particular. In previous shutdown negotiations the GOP had demanded that the federal government deny family planning funds to Planned Parenthood clinics because the organization, in an arrangement long protected by the Supreme Court, also provides abortion services paid for privately or with funds authorized by states that segregate their own Medicaid contributions to pay for abortion subsidies for poor women (Culp-Ressler 2013). President Obama refused to compromise on these issues.

Failing to enforce their will at the federal level, however, conservative Republicans have since taken their cause to like-minded states, where successful efforts to defund family planning have turned what was once a robust reproductive health safety net into a patchwork system, leaving women in many places without access to quality and affordable care. As the Guttmacher Institute reports, since 2010 five of the 19 states that include family planning line items in their budgets have made cuts "disproportionate to those aimed at other health programs" (Gold 2013). No state has rolled back women's access to health care as aggressively as Texas, where family planning programs went from serving 212,000 patients in 2010 to 75,000 in 2012, and experts predict a further decline to 61,000 in 2013 (Flynn 2013 "Title X"). Maine, Montana, and New Jersey have completely eliminated family planning funding (Gold 2013).

Against this background conservatives are now also vehemently objecting the ACA's contraceptive mandate on the grounds that it violates the religious freedom of employers. In response to this objection, the Obama administration implemented a rule that completely exempts houses of worship from the contraceptive mandate and allows employees of, or students at, religiously identified nonprofit organizations, such as hospitals and universities, to access contraceptives at no cost to their employers.

Beyond explicitly religious employers, more than 40 suits have also been filed against the mandate by for-profit businesses also opposed to providing this coverage to their employees on what they claim as religious grounds. The Supreme Court's 2013-2014 docket includes two cases that challenge the law and argue for the right of for-profit companies to exercise religious beliefs. There is existing judicial precedent on this issue: 28 states already have "contraceptive equity" laws in place requiring insurance plans covering prescription drugs to include the costs of contraception (Guttmacher 2014). State courts in New York and California have already rejected challenges to such laws on the grounds that they advance the public's interest in women's health and gender equity (Domino's Farms Corp., et al v. Kathleen Sebelius 2013). The new cases will need to address these precedents.

In addition to these legal challenges, the refusal of many states to accept federal funding for Medicaid expansion undermines the law's promise to provide health coverage for all Americans and jeopardizes reproductive health care for millions of low-income Americans (Bapat 2011). As of March 2014, 21 states are still refusing to expand Medicaid (four are considering expansion but have not confirmed), leaving more than 3.2 million women without coverage (Advisory Board). The New York Times reported that two-thirds of poor blacks and single mothers and more than half of all uninsured, low-wage workers will remain without coverage if Medicaid is not expanded universally because their incomes are not high enough to qualify for subsidies and, even if they were, the cost of insurance through the exchanges would be prohibitive.

Other women will remain uninsured for a variety of reasons: small businesses with fewer than 25 full-time employees are exempt from the obligation to provide insurance; changing life circumstances will force people to churn on and off Medicaid and/or private insurance; and "grandfathered" plans are not yet required to meet all of the ACA's mandates (though eventually all will be). There are currently no solutions for ensuring care for women who fall into these various gaps, a situation that will demand a continued, and perhaps increased, investment in Title X for the immediate future.

The program's existing shortfall is eye-opening: Title X funding regrettably has never reached a level adequate to meet national needs. The program's fiscal year 2013 budget is $278.3 million – $39.2 million below the amount budgeted for 2010. Today Title X funding is a shocking 65 percent below 1980 levels, in inflation-adjusted dollars (Gold 2012). The Obama administration has requested $327 million for fiscal year 2014 – a $49 million increase from the 2013 budget – which would simply bring the program back to pre-2010 levels (Office of Management and Budget 2013).

Experts estimate that Title X currently only serves 35 percent of the population in need, and that functioning at full capacity will cost approximately $800 million annually (Coleman 2013). This number has grown dramatically in the wake of the 2008 financial crisis, while funding levels have declined or, at best, remained flat. In 2009 and 2010, the Title X system saw 173,000 new patients, reflecting the large number of women who lost subsidized health care or moved between different insurance plans. This represented the largest increase in clientele in a decade (Coleman 2013; OPA 2012).

While needs have expanded, cuts to Title X have instead forced clinics to reduce services, supplies, hours, and staff, and therein the number of patients they are able to serve. The Title X network contracted by 440,000 patients between 2010 and 2012, from 5.22 million to 4.76 million (OPA 2012, Fowler 2013). The Guttmacher Institute reports that six in 10 Title X-supported sites are now unable to stock some contraceptive methods due to cost, particularly LARCs, which the ACA promises to cover (Gold 2012).

It is unlikely that Title X – already at further reduced levels as a result of sequestration – will face additional cuts, but it also is unlikely to see increases. Meanwhile, conservative lawmakers in some states have restricted the reach of the program to comprehensive community health care sites administered by state health departments that do not prioritize family planning, or worse, to anti-choice crisis pregnancy centers, while simply cutting specialized family planning clinics like those run by Planned Parenthood (Guttmacher 2013 "Restrictions").

State efforts to restrict family planning funding have already weakened a primary public health system upon which millions of low-income individuals rely. When Texas cut family planning providers out of Title X, four of the eight Planned Parenthood clinics in the Rio Grande Valley – one of the nation's most underserved regions – were forced to close, and those that remain open have reduced hours, cut staff, and stopped providing the most effective long acting methods of birth control because they are too costly (CRR and NLIRH 2013).

The ACA alone will not solve the myriad problems facing low-income women and their families, but it can profoundly improve their ability to lead healthy – and therefore more economically secure – lives. The ACA's promise will be compromised, however, if conservatives erode the contraceptive mandate, refuse funding for Medicaid expansion, and further decimate Title X. Providing contraception and other essential reproductive health care to the millions of women whose needs are still unmet will require unqualified implementation of the ACA, along with continued support for critical public healthcare infrastructure.

A HISTORY OF SHIFTING POLITICAL ALLIANCES OVER BIRTH CONTROL

Revisiting the history of government support for family planning reminds us that investing in women's reproductive health and bodily autonomy was once broadly supported by Democratic and Republican lawmakers, and by the general public. It might also suggest a way out of our current political impasse.

Nearly a century ago, birth control pioneer Margaret Sanger was jailed for establishing the country's first birth control clinic in Brooklyn, New York. Birth control remained illegal under Victorian era statutes that defined it as obscene, and her clinic was a deliberate effort to test the law. The clinic was shut down by the police just a few days after opening, but by then nearly 500 women had shown up and received care, demonstrating an enormous unmet need for services, then as now (Chesler 1992).

The decision on Sanger's court case licensed physicians to prescribe contraception for women with a broad range of medical reasons for using it. Family planning gained in moral and social legitimacy and, by increments, in legal status, during the following decades. Local clinics organized by Sanger and her followers came together under the national umbrella of the Planned Parenthood Federation of America, while others remained active but unaffiliated, quietly providing the only sources of reproductive health and family planning services for women unable to afford private doctors (Chesler 2012). Sanger went to Washington during the Great Depression, hoping that Franklin and Eleanor Roosevelt would address the problem and incorporate public subsidies of contraception into the New Deal's social safety net as a matter of simple justice. She mounted an impressive lobby but failed to anticipate the force the opposition to this idea would generate from the powerful coalition of urban Catholics and rural Protestant fundamentalists who held New Deal Democrats captive, much as they have today captured the Republican Party.

The U.S. government did not fully overcome moral and religious objections to birth control until the Supreme Court protected contraceptive use for married Americans under the privacy doctrine created in 1965 by Griswold v. Connecticut. This landmark decision then freed President Lyndon Johnson to provide public support for domestic family planning programs as a dimension of his high profile War on Poverty and to fund family planning programs abroad as part of the country's expanding international development programs. With little primary care public health infrastructure available at the time, the federal government contracted with Planned Parenthood and other such organizations to provide expanded services. In 1972, the right to use contraception was extended to unmarried women in Eisenstadt v. Baird, and clinics were officially opened to single women (Chesler 2012).

This was in many ways a unique moment in the long history of U.S. controversy over birth control. New contraceptive technologies, including the hormonal birth control pill and the IUD, made widespread distribution of family planning possible for the first time. A second wave of feminism drove important cultural changes, including enhanced awareness of sexual and reproductive autonomy as an essential foundation for women's equality. At the same time, public health advances set in motion dramatic worldwide population growth, and consequent fears of rising economic and political instability, especially in poor countries. Motives ranged from humanitarian to alarmist, but the virtues of public support for family planning became an issue on which progressives and conservatives suddenly could agree.

As a Democrat still fearing religious opposition to birth control, President Lyndon Johnson only took action with assurance of strong bipartisan support from his former rival, the conservative Republican Barry Goldwater, and from prominent GOP moderates in Congress like Robert Packwood of Oregon. Title X was later enacted in 1970 as an amendment to the Public Health Service Act promoted by the administration of Richard Nixon. It was also championed by then Texas Congressman George H.W. Bush and passed with broad bipartisan support.

Political considerations during the 1980 presidential election, however, soon accounted for one of the most dramatic and cynical public policy reversals in modern American politics. Governor Ronald Reagan had supported California's liberal policies on reproductive rights, and George Bush as Richard Nixon's Ambassador to the United Nations helped shape the UN's population programs. But Republican operatives in 1980 saw a potential fissure in the traditional New Deal coalition. They made a deliberate appeal to win over the votes of Catholics uncomfortable with the Supreme Court's 1973 decision in Roe v. Wade guaranteeing privacy protections to abortion, and of white Southern Christians angry about Democratic support for affirmative action and other aspects of the Civil Rights agenda. Opposition to abortion – along with the assumption that access to birth control promoted irresponsible behavior – became a GOP litmus test, and both Republican presidential hopefuls publicly changed their views.

The 1990s brought the election of Bill Clinton as America's first publicly pro-choice president along with the Supreme Court's crafting of a compromise decision in Planned Parenthood v. Casey, which preserved the core privacy doctrine of Roe v. Wade but by establishing a new standard of "undue burden" also opened the door to the hundreds of new state restrictions on abortion access since put in place. The perceived double threat of a publicly pro-choice president and a court that upheld Roe unleashed a new and even more powerful conservative backlash that took aim not only at abortion, but at contraception and sex education as well.[12]

Exploiting inevitable tensions in the wake of profound social and economic changes occurring across the country as the result of altered gender roles and expectations – changes symbolized and made all the more palpable by Hillary Clinton's activist role as First Lady – conservatives, with the support of powerful right-wing foundations and think tanks, poured millions of dollars into research and propaganda promoting family values and demonizing reproductive freedom. A relentless stigmatizing of contraception and abortion, along with campaigns of intimidation and outright violence against Planned Parenthood and other providers, had a chilling effect on politicians generally shy of social controversy.

Since the 1996 welfare reform legislation, not only has access to abortion been curtailed, but critical funds for family planning programs at home and abroad have also declined in real dollars (Flynn "Title X"; Speidel et al. 2009). Confidence that a relatively small investment in family planning today will pay large dividends in the future no longer enjoys bi-partisan support. And low-income women are suffering the consequences.

Opponents of public subsidies for contraception and abortion tend to claim the moral high ground. But to the contrary, the history of shifting alliances on this issue demonstrates that their motives have often been as much

[12] Initial backlash against comprehensive sexuality education began in 1981, when the federal government began funding abstinence-only-until marriage programs under President Ronald Reagan (SIECUS).

political as ideological. The recent partisan realignment that lured social conservatives to the Republican Party is only one generation in the making, and there is reason to believe it may soon run its course.

With the GOP now captive to a base of fundamentalists who are out of touch with prevailing views on birth control, it is increasing losing the support of centrist independent voters, most especially single women and women of color, who are necessary to win national elections (Wilson 2012). For years, a substantial majority of Americans have held progressive views on a range of social issues, but unlike a zealous minority on the other side, these progressives and moderates have not necessarily privileged these issues over important questions of economics or national security that mattered more to them at election time.

That's what is changing as Republicans veer further to the right. President Obama's attention-grabbing refusal in the spring of 2012 to cave to John Boehner's demand that he defund Planned Parenthood as part of a deal to reduce the federal deficit elicited a sudden surge in his popularity. Campaign polling on President Obama then uncovered a huge opening in the highly contested demographic of women ages 20 to 39 who were furious about Republican social extremism. An astonishing 80 percent of them disapproved of Republican tactics (Obama Campaign 2011). When the Catholic hierarchy then challenged the ACA's contraceptive mandate on grounds of religious freedom, polling showed identical patterns, with a solid majority of support overall – including a majority of Catholic voters – for the administration's technical fix to maintain full coverage by allowing Catholic hospitals to have their insurance companies cover the costs of contraception, rather than the institutions themselves.

The Obama administration's determination on this issue was a deliberate political calculation – not a blunder, as many high-powered liberal and conservative pundits first mistakenly characterized it. And the calculation paid off. The president won re-election with the largest gender gap on record. Zeroing in on issues of women's health and equity – he mentioned Planned Parenthood by name four times in the third of four televised debates – the president won a solid re-election victory, carrying 55 percent of women voters who comprised 53 percent of the vote overall (Roper Center 2013). Mindful of these numbers – and with the added ballast of what amounted to a daily drumbeat of progressive television talk and comedy that pilloried Republican prudery during the campaign – Congressional Democrats have intensified their resolve to keep up the fight in this year's mid-term elections. They will have to if they hope to reverse already enacted legislation that is curtailing women's access to care, and if they want to prevent other states from moving forward with laws that deliberately defund or restrict reproductive health care.

Progressive policy advocates should follow this lead. In supporting access to reproductive rights and healthcare – in understanding it as a way to promote responsible behavior and not the other way around – we have long had common sense on our side. If the polls are correct, we now also have a solid majority of the American public, with 89 percent of Americans, according to one recent survey, approving contraception as a general matter. (Newport 2012) With opposition to the Affordable Care Act intensifying, fewer are willing to say they approve of its contraceptive mandate, but even there opinion is pretty evenly split with a slight majority of the most recent sample still in favor.

CONCLUSION AND RECOMMENDATIONS

The United States is the only industrialized country where high rates of unintended pregnancy remain a major challenge. Elsewhere, more robust investments in social safety nets, sex education, and family planning outreach have had dramatic results (Kirby 2007, Secura 2014). The ACA, if unconditioned, promises to expand resources and eliminate longstanding disparities in service provision that discriminate against poor women and contribute to overall inequality. Meeting the family planning needs of all women is a critical step in fulfilling the rights of low-income women and in expanding economic opportunity to those women and their families. Doing so requires the following policy commitments:

- The contraceptive mandate – a cornerstone of the ACA – must be upheld. If it is overturned, women who already benefit from family planning coverage will lose it, and those with still unmet need will remain without

care. The legislation's contraceptive mandate reflects the Obama administration's recognition – and the recommendation of a broad community of medical experts – that family planning is central to the overall health and social and economic well-being of women and their families. Stripping the ACA of the contraceptive mandate would significantly weaken the law's impact on women's health and establish a dangerous precedent permitting employers to make decisions about a far broader range of services permitted under the auspices of employer-based health insurance.

- Despite the Supreme Court's decision in this matter, all states should follow the prudent course of accepting federal funding for Medicaid expansion. Failing to expand Medicaid eligibility makes no rational economic sense and only serves to undermine the ACA. Women most at risk of unintended pregnancy (many living in states that already have among the highest unintended pregnancy rates in the country) will fall into the coverage gap. Their physical health will suffer and unwanted pregnancy will increase, with increased personal and public costs as a result of unwanted pregnancy and abortion. As a recent study by the Center for Reproductive Rights and the National Latina Institute for Reproductive Health demonstrates, not just individual health outcomes suffer, but also the economic stability of families and communities.[13]

- The legislation's existing requirement that immigrant women wait five years before qualifying for coverage should be eliminated. Millions of women living and working legally in the United States are unable to access any form of health care, and state-level assaults on family planning have destroyed the health infrastructure on which these women relied as their main point of care. These women are forced to choose between contraception and feeding their children, are unable to obtain screenings and follow up appointments for cancer checks, and expose themselves to physical violence and the threat of not being able to return in order to access needed care and services in Mexico.

- Moving forward, levels of Title X funding should be tied directly to estimates of unmet need for family planning. The marginal cost of expanding the program is low, given the program's extraordinary success. Women newly insured under the ACA will require and seek out Title X clinics, while those still uninsured will continue to rely on them, especially if the Supreme Court weakens or overturns the contraceptive mandate, and if states continue to reject funding for Medicaid expansion. The Obama administration has pledged roughly $11 billion to the expansion of CHCs, which must include family planning services, but they will take time to build. Meanwhile, targeted family planning clinics that do not qualify for these funds will continue to be necessary and will continue to rely on Title X.[14]

This paper has attempted to remind the reader of just how high the stakes are in the fight over national healthcare. It has examined the positive consequences of extending insurance broadly – and of covering contraception specifically – on the health of poor women and their children, as well as on their social and economic well-being. It has also interrogated the politics of the issue and found a solid majority of American voters in support.

Around the world, access to family planning is now widely understood as a fundamental human right – essential to individuals and to the social and economic progress of the communities in which they live. The United States is not exceptional in this regard. Fighting to maintain the integrity of the ACA, a landmark piece of legislation, will require continued vigilance, but the consequences of not doing so are simply too high. This is a fight we simply cannot give up on, and it's one we can win if only we maintain our resolve.

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[13] See *Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley* (2013).

[14] Many Title X clinics are not categorized as Federally Qualified Health Centers, either because they did not apply for such status or because they do not provide the full range of required primary care services such as eye, ear, dental, radiologic services, etc. Those clinics will not be eligible for additional federal funding through the ACA.

REFERENCES

Abramowitz, Mimi. 2012. "The Feminization of Austerity." New Labor Forum. 21(1): 32-41. Accessed March 1, 2014 (http://www.hunter.cuny.edu/socwork/faculty/Feminization%20of%20Austerity.pdf?auth=0&type=summary&url=/journals/new_labor_forum/v021/21.1.abramovitz.html).

Amnesty International. 2010. "Deadly Delivery: The Maternal Health Care Crisis in the USA." Accessed February 28, 2014 (http://www.amnestyusa.org/sites/default/files/pdfs/deadlydelivery.pdf).

Bapat, Sheila. 2012. "Details & Devils: Contraceptive Coverage, Health Reform's Medicaid Expansion and the Enduring Importance of the States." Center for Women Policy Studies. Accessed December 4, 2013 (http://www.centerwomenpolicy.org/programs/health/statepolicy/REPRO_DetailsDevils_SheilaBapat.pdf.pdf).

Capps, Randy, James D. Bachmeier, Michael Fix, and Jennifer Van Hook. 2013. "A Demographic, Socioeconomic, and Health Coverage Profile of Unauthorized Immigrants in the United States." Migration Policy Institute.

Carter, Marion, Kathleen Desilets, Lorrie Gavin, Sue Moskosky, and Jill Clark. 2014. "Trends in Uninsured Clients Visiting Health Centers Funded by the Title X Family Planning Program — Massachusetts, 2005–2012." Morbidity and Mortality Weekly Report 63(3):59-62. Accessed February 18, 2014 (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6303a3.htm?s_cid=mm6303a3_w).

Center for Reproductive Rights. "Addressing Disparities in Reproductive and Sexual Health Care in the U.S." Accessed February 28, 2014 (http://reproductiverights.org/en/node/861).

Center for Reproductive Rights (CRR), National Latina Institute for Reproductive Health (NLIRH). 2013. "Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley." Accessed January 15, 2014 (http://www.nuestrotexas.org/pdf/NT-spread.pdf).

Coleman, Clare. Personal interview, January 28, 2013.

Chesler, Ellen. 1992. *Woman of Valor: Margaret Sanger and the Birth Control Movement in America*. New York: Simon and Schuster.

Chesler, Ellen. 2012. "Margaret Sanger." In Oxford Encyclopedia of American History, edited by Lynn Dumenil. Oxford: Oxford University Press.

Covert, Bryce. 2014. "Workers In A Third State Can Now Take Paid Family Leave." Think Progress, January 2. Accessed February 17, 2014 (http://thinkprogress.org/economy/2014/01/02/3110281/rhode-island-paid-family-leave-effect/).

Cuellar, Alison, Adelle Simmons, and Kenneth Finegold. 2012. ASPE Research Brief: The Affordable Care Act and Women. Washington, DC: U.S. Department of Health and Human Services. Accessed June 2013 (http://aspe.hhs.gov/health/reports/2012/ACA&Women/rb.pdf).

Culp-Ressler, Tara. 2013. "Republicans Are Still Coming For Your Birth Control, Even If It Takes A Government Shutdown To Do It." Think Progress, September 30. Accessed October 1, 2013 (http://thinkprogress.org/health/2013/09/30/2702731/republicans-birth-control-government-shutdown/).

DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica C. Smith. 2013. Income, Poverty, and Health Insurance Coverage in the United States: 2012. Washington, DC: U.S. Government Printing Office. Accessed February 18, 2014 (http://www.census.gov/prod/2013pubs/p60-245.pdf).

Domino's Farms Corp., et al. v. Kathleen Sebelius, et al. No. 13-1654 (Mich, 2013). "Brief of the National Women's Law Center and 17 other national, regional, state and local organizations as amici curiae in support of defendants-appellants and reversal." Accessed November 20, 2013 (http://www.nwlc.org/sites/default/files/domino_farms_amicus_8-13-13.pdf).

Durkin, Erin. 2013. "Teen Pregnancy down 27% in New York City over the last decade: report." New York Daily News, February 2. Accessed November 30, 2013 (http://www.nydailynews.com/new-york/teen-pregnancy-27-nyc-report-article-1.1253933#ixzz2o2Z8xXIA).

Finer, Lawrence B. and Mia R. Zolna, MPH. 2014. "Shifts in Intended and Unintended Pregnancies in the United States, 2001–2008." American Journal of Public Health. 104(S1):S43-S48. Accessed March 1, 2014 (https://www.guttmacher.org/pubs/journals/ajph.2013.301416.pdf).

Flynn, Andrea. 2013. "New Texas Abortion Law Could be Worst Yet for Poor Women." Next New Deal. Accessed March 1, 2014 (http://www.nextnewdeal.net/new-texas-abortion-law-could-be-worst-yet-poor-women).

Flynn, Andrea. 2013. "The Title X Factor: Why the Health of America's Women Depends on More Funding for Family Planning." Roosevelt Institute. Accessed December 1, 2013 (http://rooseveltinstitute.org/sites/all/files/2013_10_28_Flynn_Title_X.pdf).

Fowler, Christina I. 2013. "2012 Family Planning Annual Report: Highlights and Selected Trends." Presented at the 2013 National Title X Grantee Meeting, August 1, Seattle, WA. Accessed September 25, 2013 (http://www.caiglobal.org/caistage/images/pdfs/ntc/Grantee2013/plenary-8-1-13-830am-4-cfowler.pdf).

Frost, Jennifer J., Lawrence B. Finer, and Athena Tapales. 2008. "The Impact of Publicly Funded Family Planning Clinic Services on Unintended Pregnancies and Government Cost Savings." Journal of Health Care for the Poor and Underserved 19(3):778–796.

Frost, Jennifer J. and Laura Duberstein Lindberg. 2013. "Reasons for using contraception: Perspectives of US women seeking care at specialized family planning clinics." Contraception 87(4):765-472. Accessed February 18, 2013 (http://www.guttmacher.org/pubs/journals/j.contraception.2012.08.012.pdf).

Frost, Jennifer J., Mia R. Zolna, and Lori Frohwirth. 2013. "Contraceptive Needs and Services, 2010." New York: Guttmacher Institute. Accessed September 25, 2013 (http://www.guttmacher.org/pubs/win/contraceptive-needs-2010.pdf).

Fuentes Liza, Veronica Bayetti Flores, and Jessica Gonzalez-Rojas. 2010. "Removing Stigma: Towards a Complete Understanding of Young Latinas' Sexual Health." New York: National Latina Institute for Reproductive Health. Accessed March 1, 2014 (http://latinainstitute.org/sites/default/files/publications/special-reports/NLIRH-HPWhite-5310-F2.pdf).

Furstenberg, Frank. 2007. Destinies of the Disadvantaged: The Politics of Teenage Childbearing. New York: Russell Sage Foundation.

Gabe, Thomas. 2011. Welfare, Work, and Poverty Status of Female- Headed Families with Children: 1987-2009. Congressional Research Service. Accessed December 4, 2013 (http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1852&context=key_workplace).

Gold, Rachel Benson. 2001. "Title X: Three Decades of Accomplishment." The Guttmacher Report on Public Policy 4(1). Accessed May 15, 2013 (http://www.guttmacher.org/pubs/tgr/04/1/gr040105.html).

Gold, Rachel Benson. 2012. "Going the Extra Mile: The Difference Title X Makes." Guttmacher Policy Review 15 (2):14-15. Accessed April 2013 (http://www.guttmacher.org/pubs/gpr/15/2/gpr150213.pdf).

Gold, Rachel Benson. 2013. "Besieged Family Planning Network Plays Pivotal Role." Guttmacher Policy Review 16 (1):13-17. Accessed October 7, 2013 (http://www.guttmacher.org/pubs/gpr/16/1/gpr160113.pdf).

Guerra, Maria. 2013. "Fact Sheet: The State of African American Women in the United States." Accessed February 27, 2014 (http://www.americanprogress.org/issues/race/report/2013/11/07/79165/fact-sheet-the-state-of-african-american-women-in-the-united-states/).

Guttmacher Institute. 2009. "A Real-Time Look at the Impact of the Recession on Women's Family Planning and Pregnancy Decisions." Accessed November 30, 2013 (http://www.guttmacher.org/pubs/RecessionFP.pdf).

Guttmacher Institute. 2013. "Facts on American Teens' Sexual and Reproductive Health." Accessed February 24, 2014 (http://www.guttmacher.org/pubs/FB-ATSRH.html)

Guttmacher Institute. 2014. "Insurance Coverage of Contraceptives." Accessed February 24, 2014 (http://www.guttmacher.org/statecenter/spibs/spib_ICC.pdf).

Guttmacher Institute. 2013. "State Family Planning Funding Restrictions." Accessed December 4, 2013 (http://www.guttmacher.org/statecenter/spibs/spib_SFPFR.pdf).

Guttmacher Institute. 2013. "Unintended Pregnancy in the United States." Accessed November 30, 2013 (http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html).

Hamilton, Brandy E., Joyce A. Martin, M.P.H., and Stephanie J. Ventura. "Births: Preliminary Data for 2011." National Vital Statistics Reports. 61(5). Table 2. Accessed March 1, 2014 (http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_05.pdf).

Hartocollis, Anemona. 2012. "More Access to Contraceptives in City Schools." The New York Times, September 23. Accessed November 30, 2012 (http://www.nytimes.com/2012/09/24/nyregion/resistance-low-to-school-contraceptives-effort-new-york-health-officials-say.html).

Haskins, Ron. 2012. "Combating Poverty: Understanding New Challenges for Families." Testimony to the United States Senate Committee on Finance. Accessed March 1 2014 (http://www.brookings.edu/research/testimony/2012/06/05-poverty-families-haskins).

Health Resources and Services Administration (HRSA), Department of Health and Human Services. 2013. Fiscal Year 2014: Justification of Estimates for Appropriations Committees. Accessed September 27, 2013 (http://www.hrsa.gov/about/budget/budgetjustification2014.pdf).

Health Resources and Services Administration (HRSA), Department of Health and Human Services. "Women's Preventive Services Guidelines." Accessed October 1, 2013 (http://www.hrsa.gov/womensguidelines).

Hildebrandt, PhD, RN, ANP, Eugenie, and Patricia Stevens, PhD, RN. 2009. "Impoverished Women With Children and No Welfare Benefits: The Urgency of Researching Failures of the Temporary Assistance for Needy Families Program." American Journal of Public Health. 99(5): 793–801. Accessed March 1, 2014 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2667863/#_ffn_sectitle).

Jackson, Mareshah. 2013. "Fact Sheet: The State of Latinas in the United States." Accessed February 28, 2013 (http://www.americanprogress.org/issues/race/report/2013/11/07/79167/fact-sheet-the-state-of-latinas-in-the-united-states/).

Jones, Rachel K. and Jenna Jerman. 2014. "Abortion Incidence and Service Availability in the United States, 2011." Perspectives on Sexual and Reproductive Health 46:1. Accessed February 18, 2014 (http://www.guttmacher.org/pubs/journals/psrh.46e0414.pdf).

Kaiser Family Foundation. 2012. "A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion."Accessed April 1, 2013 (http://kff.org/health-reform/issue-brief/a-guide-to-the-supreme-courts-decision/).

Kaiser Family Foundation. 2012. "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis." Accessed April 1, 2013 (http://www.kff.org/medicaid/upload/8384.pdf).

Kaufman, Marc. 2006. "Unwanted Pregnancies Rise for Poor Women." The Washington Post. Accessed March 1, 2014 (http://www.washingtonpost.com/wp-dyn/content/article/2006/05/04/AR2006050400820.html).

Kearney, Melissa S. and Phillip Levine. 2014. "Teen Births Are Falling: What's Going On?" Economic Studies at Brookings. Accessed March 11, 2014 (http://www.brookings.edu/~/media/research/files/reports/2014/03/teen%20births%20falling%20whats%20going%20on%20kearney%20levine/teen_births_falling_whats_going_on_kearney_levine).

Kim, Susanna. 2013. "Record Number of Female Breadwinners, According to Pew." ABC News, May 29. Accessed December 4, 2013 (http://abcnews.go.com/Business/record-number-female-primary-breadwinners-show-stark-differences/story?id=19280418).

Kirby, Douglas. 2008. "The Impact of Abstinence and Comprehensive Sex and STD/HIV Education Programs on Adolescent Sexual Behavior." Sexuality Research and Social Policy. 5(3):18-27. Accessed March 1, 2014 (http://www.cfw.org/document.doc?id=283).

Kirby, Douglas. 2007. "Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases." Accessed March 1, 2014 (http://thenationalcampaign.org/sites/default/files/resource-primary-download/EA2007_full_0.pdf).

Ku, Leighton, Emily Jones, Peter Shin, Fraser Rothenberg Byrne, and Sharon K. Long. 2011. "Safety-Net Providers After Health Care Reform: Lessons From Massachusetts." JAMA Internal Medicine 171(15):1379-1384. Accessed September 1, 2013 (http://archinte.jamanetwork.com/article.aspx?articleid=1105879).

Lyter, Deanna M., Melissa Sills, and Gi-Taik Oh. 2002. "Children in Single-Parent Families Living in Poverty Have Fewer Supports after Welfare Reform." Institute for Women's Policy Research. Accessed March 1, 2014 (http://www.iwpr.org/publications/pubs/children-in-single-parent-families-living-in-poverty-have-fewer-supports-after-welfare-reform/at_download/file).

Macartney, Suzanne, Alemayehu Bishaw, and Kayla Fontenot. 2013. "Poverty Rates for Selected Detailed Race and Hispanic Groups by State and Place: 2007–2011." American Community Survey Briefs. Accessed March 1, 2014 (http://www.census.gov/prod/2013pubs/acsbr11-17.pdf).

McKernan, Signe-Mary and Caroline Ratcliffe. 2006. "The Effect of Specific Welfare Policies on Poverty." Urban Institute. Accessed March 1, 2014 (http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2205845).

Moynihan, Daniel Patrick. 1965. "The Negro Family: The Case For National Action." Accessed February 25, 2014 (http://www.dol.gov/dol/aboutdol/history/webid-meynihan.htm).

Nathan, Richard P. and Thomas L. Gais. 2001. "Is Devolution Working? Federal and State Roles in Welfare." Brookings Institution. Accessed March 1, 2014 (http://www.brookings.edu/research/articles/2001/06/summer-welfare-nathan).

"Teen Pregnancy and Overall Child Well-Being." 2007. National Campaign to Prevent Teen Pregnancy. Accessed December 4, 2013 (http://thenationalcampaign.org/resource/why-it-matters-teen-pregnancy-and-overall-child-wellbeing).

"Unplanned Pregnancy Among Unmarried Young Women." 2012. National Campaign to Prevent Teen Pregnancy. Accessed December 4, 2013 (http://www.thenationalcampaign.org/resources/pdf/briefly-unplanned-pregnancy-among-unmarried.pdf).

Newport, Frank. 2012. "Americans, Including Catholics, Say Birth Control Is Morally OK." Gallup Politics. Accessed March 20, 2014 (http://www.gallup.com/poll/154799/americans-including-catholics-say-birth-control-morally.aspx)

National Family Planning and Reproductive Health Association (NFPRHA). March 2013. "Medicaid Family Planning Expansion Programs: Essential Coverage Post-ACA Implementation." Accessed April 1, 2013 (http://www.nationalfamilyplanning.org/document.doc?id=782).

National Women's Law Center. 2013. "Nondiscrimination Protection in the Affordable Care Act: Section 1557." Accessed October 9, 2013 (http://www.nwlc.org/resource/nondiscrimination-protection-affordable-care-act-section-1557).

Obama Campaign. November 3, 2011. Official Campaign Presentation to the Planned Parenthood Federation of America Leadership Council.

Office of Management and Budget. 2013. "Fiscal Year 2014 Budget of the U.S. Government." Accessed September 1, 2013 (http://www.whitehouse.gov/sites/default/files/omb/budget/fy2014/assets/budget.pdf).

Office of Population Affairs, U.S. Department of Health and Human Services. 2012. "Family Planning Annual Reports." Accessed September 1, 2013. (http://www.hhs.gov/opa/title-x-family-planning/research-and-data/fp-annual-reports/#fpar).

Peterson, Janice Ph.D. 2002. "Feminist Perspectives on TANF Reauthorization: An Introduction to Key Issues for the Future of Welfare Reform." Institute for Women's Policy Research. Accessed March 1, 2014 (http://www.iwpr.org/publications/pubs/feminist-perspectives-on-tanf-reauthorization-an-introduction-to-key-issues-for-the-future-of-welfare-reform/at_download/file).

Roper Center. N.d. "US Elections; How Groups Voted in 2012" Accessed December 5, 2013 (http://www.ropercenter.uconn.edu/elections/how_groups_voted/voted_12.html).

Rustgi, Sheila A., Michelle M. Doty, and Sara R. Collins. 2009. Women at Risk: Why Many Women Are Forgoing Needed Health Care: An Analysis of the Commonwealth Fund. The Commonwealth Fund. Accessed November 22, 2013 (http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/May/Women%20at%20Risk/PDF_1262_Rustgi_women_at_risk_issue_brief_Final.pdf).

Secura, Gina M. PhD, MPH, Tiffany Adams, BA; Christina M. Buckel MSW; Qiuhong Zhao MS; Jeffrey F. Peipert MD, PhD. 2014. "Change in Sexual Behavior With Provision of No-Cost Contraception." Obstetrics and Gynecology. Accessed March 12, 2014 (http://journals.lww.com/greenjournal/Abstract/publishahead/Change_in_Sexual_Behavior_With_Provision_of.99511.aspx).

SIECUS. 2010. "A History of Federal Funding for Abstinence-Only-Until-Marriage Programs." Accessed February 28, 2014 (http://www.siecus.org/index.cfm?fuseaction=page.viewPage&pageID=1340&nodeID=1)

Sonfield, Adam. 2012. "Beyond Contraception: The Overlooked Reproductive Health Benefits of Health Reform's Preventive Services Requirement." Guttmacher Policy Review 15(4):18-24. Accessed September 9, 2013 (http://www.guttmacher.org/pubs/gpr/15/4/gpr150418.pdf).

Sonfield, Adam, Jennifer J. Frost, and Rachel Benson Gold. 2011. Estimating the Impact of Expanding Medicaid Eligibility For Family Planning Services: 2011 Update. Guttmacher Institute. Accessed June 1, 2013 (http://www.guttmacher.org/pubs/Medicaid-Family-Planning-2011.pdf).

Speidel, Joseph J., et al. "Making the Case for U.S. International Family Planning Assistance." Accessed March 1, 2014 (http://www.jhsph.edu/sebin/u/d/MakingtheCase.pdf).

The Advisory Board Company. 2014. "Where the States Stand on Medicaid Expansion." Accessed March 1, 2014 (http://www.advisory.com/daily-briefing/resources/primers/medicaidmap).

The Commonwealth Fund. 2013. "New Survey of Young Adults: 7.8 Million Gained New or Better Coverage Through Affordable Care Act, But Only 27 Percent Are Aware of Health Insurance Marketplaces; Millions Will Remain Uninsured If States Don't Expand Medicaid." Accessed October 9, 2013 (http://www.commonwealthfund.org/News/News-Releases/2013/Aug/New-Survey-of-Young-Adults.aspx).

Trenholm, Christopher, Barbara Devaney, Kenneth Fortson, Melissa Clark, Lisa Quay, and Justin Wheeler. 2008. "Impacts of abstinence education on teen sexual activity, risk of pregnancy, and risk of sexually transmitted diseases." Journal of Policy Analysis and Management. 27(2):255-276. Accessed March 1, 2014 (http://onlinelibrary.wiley.com/doi/10.1002/pam.20324/abstract).

U.S. Bureau of Labor Statistics. 2013. "A Profile of the Working Poor, 2011." Accessed December 4, 2013 (http://www.bls.gov/cps/cpswp2011.pdf).

U.S. Department of Health and Human Services (HHS). "Family Planning." Accessed November 30, 2013 (http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=13).

U.S. Department of Health and Human Services (HHS). 2012. "The Affordable Care Act and Health Centers." Accessed September 15, 2013 (http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf).

U.S. Census Bureau. "Poverty." Accessed December 1, 2013 (http://www.census.gov/hhes/www/poverty/about/overview/).

Washington University at St. Louis. 2012. "Contraceptive Choice Project." Accessed September 1, 2013 (http://choiceproject.wustl.edu/#CHOICE).

Whitaker, Morgan. 2014. "Family decay, single moms get blame for poverty from GOP." MSNBC. Accessed February 18, 2014 (http://www.msnbc.com/politicsnation/gop-single-moms-still-blame-poverty).

Williams, Kristi. 2014. "Promoting marriage among single mothers: An ineffective weapon in the war on poverty?" Council on Contemporary Families. Accessed February 18, 2014 (http://www.contemporaryfamilies.org/marriage-ineffective-in-war-on-poverty-report).

Wilson, David. 2012. "The Elephant in the Exit Poll Results: Most White Women Supported Romney." Accessed March 1, 2014 (http://www.huffingtonpost.com/david-c-wilson/the-elephant-in-the-exit_b_2094354.html).

Wood, Susan, Debora Goldberg, Tishra Beeson, Brian Bruen, Kay Johnson, Holly Mead, Peter Shin, Julie Lewis, Shavon Artis, Katherine Hayes, Merle Cunningham, Xiaoxiao Lu, and Sara Rosenbaum. 2013. "Health Centers and Family Planning: Results of a Nationwide Study." George Washington University School of Public Health and Health Services. Accessed April 1, 2013 (http://sphhs.gwu.edu/departments/healthpolicy/publications/Health_Centers_and_Family_Planning.pdf).

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