Washington and Lee Journal of Civil Rights and Social Justice

Volume 24 | Issue 2 Article 8

4-1-2018

Contraception Matters: Rights, Class, and Context

Naomi Cahn
George Washington University Law School

Contraception Matters: Rights, Class, and Context

Naomi Cahn[*]

Table of Contents

Access to contraception is an increasingly critical issue at a time when the contraceptive mandate of the Affordable Care Act is under attack and just under half of all pregnancies are unintended.[1] In line with the goals of the journal and the theme of

* Harold H. Greene Chair Professor of Law, The George Washington University Law School. This essay is a lightly edited transcript of a keynote dinner speech, and draws on work with Professor June Carbone, University of Minnesota Law School. Thanks to Erica Sieg and Kendall Manning for their work on this essay, and thanks to Mohammad Zaheerudin for his research and statistical expertise.

1. *See* Richard Wolf, *Second Federal Court Blocks Trump Contraception Rule*, USA TODAY (Dec. 21, 2017), https://www.usatoday.com/story/news/politics/2017/12/21/second-federal-judge-blocks-trump-contraception-rule/974820001/ (on file with the Washington & Lee Journal of Civil Rights & Social Justice); *see also Reproductive Health: Unintended Pregnancy Prevention*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/reproductivehealth/contraception/unintendedpregnancy/index.htm (last updated Dec. 23, 2016) (noting that in 2011, 45% of pregnancies were unintended) (on file with the Washington & Lee Journal of Civil Rights & Social Justice). An unintended pregnancy can be either Mistimed means that the women became pregnant when she was not intending to do so; it simply means the pregnancy was earlier than she desired. By contrast, an unwanted simply means the woman did not want any, or did not want any

this symposium—*Taking the Pulse: Understanding the Complexities of Healthcare Law*—I want to look at the relationship between contraception and social justice and show how legal regulation of this healthcare matter is interrelated and entwined with socio-economic opportunity and with political gridlock.

As a legal matter, contraception is not just a matter of health regulation but is also grounded in constitutional doctrine—the right of privacy and related doctrines. While access to contraception is often thought of as an issue of women's health, women's use of contraception also profoundly affects the economy and the family (and men). Moreover, it also implicates an ideological war that, at its center, concerns the modernization of the economy, women's status, and socioeconomic opportunity.[2] And it is shaped by socioeconomic class.

The regulation of contraception shows many of the political complexities that underlie the operation of our healthcare system more generally. Moreover, the means for accessing contraception, women's use of contraception, and the implications of using or not

---

more, children. As discussed later, rates of unwanted v. mistimed births vary depending on the mother's education, race, and income; for example, more than half of unintended births to non-high school graduates are unwanted compared to 24% for college graduates. *See infra* notes 43–44; Isabel Sawhill et al., *The Impact of Unintended Childrearing on Future Generations* CTR. ON CHILD. & FAMILIES BROOKINGS 5 (Sept. 2014), https://www.brookings.edu/wp-content/uploads/2016/06/12_impact_unintended_childbearing_future_sawhill.pdf (on file with the Washington & Lee Journal of Civil Rights & Social Justice). A slightly different way of looking at the same data shows that close to one-fourth of all births to women with less than a high school education are unwanted, compared to less than 5% for college graduates. CHILD TRENDS DATABANK, UNINTENDED BIRTHS: INDICATORS OF CHILD AND YOUTH WELLBEING fig. 5 (Sept. 2013), https://www.childtrends.org/wp-content/uploads/2012/10/123_Unintended_Births-1.pdf (on file with the Washington & Lee Journal of Civil Rights & Social Justice). As for attacks on the ACA, see Amy Goldstein, *Trump Administration Narrows Affordable Care Act's Contraception Mandate*, WASH. POST (Oct. 6, 2017), https://www.washingtonpost.com/national/health-science/trump-administration-could-narrow-affordable-care-acts-contraception-mandate/2017/10/05/16139400-a9f0-11e7-92d1-58c702d2d975_story.html?utm_term=.c1c7dbee6327 (on file with the Washington & Lee Journal of Civil Rights & Social Justice); Christopher Ogolla, *First Do No Harm: The Manipulation of Public Health for Non-Public Health Purposes and Its Legal Consequences*, 50 IND. L. REV. 849, 880–81 (2017); Sonia Lopez et al., *Access to Contraception*, 18 GEO. J. GENDER & L. 439, 440 (2017).

2. *See*, *e.g.*, NAOMI CAHN & JUNE CARBONE, RED FAMILIES V. BLUE FAMILIES: LEGAL POLARIZATION & THE CREATION OF CULTURE (2010) [hereinafter RED FAMILIES V. BLUE FAMILIES].

using contraception show, ultimately, a dual, class-based system. Poor women use public family planning funds and clinics to obtain contraception; middle-class and upper-income women obtain contraception through a private insurance system.[3] Consider just one statistic: a poor woman is five times as likely to get pregnant by accident as is an affluent woman.[4]

I am going to start with a brief overview of the right to contraception, then turn to information on birth control, including statistics about the use of birth control, and some of the consequences of using or not using birth control. Then I am going to turn to some of the funding issues under the Affordable Care Act before briefly addressing some solutions.

I. The Right to Contraception

Let's begin with the history and constitutionalization of the right to contraception and then turn to why it is so important.

A. Family Planning in the United States

Margaret Sanger opened the first family planning clinic in 1916.[5] She was hugely controversial for many reasons, including her association with eugenics.[6] But her clinic was the first birth

3. *See generally Women's Health Insurance Coverage*, KAISER FAM. FOUND. (Oct. 31, 2017), https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet/ (on file with the Washington & Lee Journal of Civil Rights & Social Justice). Close to sixty percent of women ages nineteen through sixty-four receive health care coverage through their own or their spouse's employer or through direct purchase, seventeen percent rely on Medicaid, and more than one in every ten women is uninsured. *Id.* For information on older women, see Naomi Cahn, *Gray Divorce,* FAM. L.Q. (forthcoming 2018) (on file with author).

4. *Unintended Pregnancy in the United States*, GUTTMACHER INST. (Sept. 2016), https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

5. *See* Sarah Primrose, *The Attack on Planned Parenthood: A Historical Analysis*, 19 UCLA WOMEN'S L.J. 165, 180 (2012) ("In 1916, Sanger opened the first contraceptive clinic in the United States.").

6. *Id.* at 202.; *see* Herbert Hovenkamp, *The Progressives: Racism and Public Law*, 59 ARIZ. L. REV. 947, 968 n. 129 (2017) ("[P]rogressive birth control advocate Margaret Sanger accepted the validity of eugenics, but countered its opponents by arguing that the solution was not abolition of birth control among the higher classes, but rather its expansion among poorer classes."); *see also*

control clinic in the United States.[7] It was shut down ten days after it was opened, which is eerily similar to what happened to Griswold in the early '60s when that medical clinic was opened and was shut down about eleven days later.[8] Notwithstanding all of her controversies, she was a very strong advocate for birth control, and she is credited with encouraging the development of the birth control pill.[9] The scientists who developed it created Enovid, the first birth control pill that became legal for contraceptive purposes in the United States.[10]

Since the development of Enovid, numerous forms of hormone-based contraceptives exist today, including not just different forms of a birth control pill, but also various long-acting reversible contraceptives.[11] The differing methods have varying rates of

---

Corinna Barrett Lain, *Three Supreme Court "Failures" and A Story of Supreme Court Success*, 69 VAND. L. REV. 1019, 1037 (2016) ('Those least fit to carry on the race are increasing most rapidly,' wrote progressive feminist and birth control advocate Margaret Sanger, echoing prevailing wisdom at the time."); *see generally* Margaret Sanger, *The Eugenic Value of Birth Control Propaganda*, 5 BIRTH CONTROL R. 10, 5 (1921).

7. Primrose, *supra* note 5, at 180.

8. *See* Griswold v. Connecticut, 381 U.S. 479, 480 (1965) (noting that the Planned Parenthood League of Connecticut's Center in New Haven was open from November 1 to November 10, 1961); *see also* Primrose, *supra* note 5, at 191 ("In an effort strikingly similar to Margaret Sanger's first clinic . . . , Estelle Griswold, the Executive Director of the Planned Parenthood League of Connecticut . . . opened a Planned Parenthood clinic in the state to test the law. Within ten days, police arrested them for violating the state contraceptive ban.").

9. *See* Primrose, *supra* note 5, at 184 ("Margaret Sanger had a role in developing the contraceptive pill. She helped recruit the necessary funding that allowed for both preliminary research and the first clinical trials of what is now known as 'the pill.'"); *see also* Maryam T. Afif, *Prescription Ethics: Can States Protect Pharmacists Who Refuse to Dispense Contraceptive Prescriptions?*, 26 PACE L. REV. 243, 245–46 (2005) (explaining that Margaret Sanger's activism helped provide the support needed to research and invest what became the birth control pill); LINDA GORDON, THE MORAL PROPERTY OF WOMEN: A HISTORY OF BIRTH CONTROL POLITICS IN AMERICA 145 (2002) ("The entire future course of birth control in the United States was influenced by Sanger's European education.").

10. *See* Nicholas Bakalar, *Birth Control Pills*, *1957*, N.Y. TIMES (Oct. 25, 2010), http://www.nytimes.com/2010/10/26/health/26first.html ("On Sept. 19, 1958 . . . A.P. dispatch headlined 'Pill Held Success as Contraceptive' reported an announcement by Dr. John Rock, ... Also not mentioning Enovid by name, the article said that 'a 50-cent pill to prevent pregnancy had proved 100 percent effective . . . .'") (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

11. *See* Pamela Verma Liao & Janet Dollin, *Half a Century of the Oral Contraceptive Pill: Historical Review and View to the Future*, 56 CAN. FAM.

effectiveness.[12] Those that are hormonally based have the lowest rates of failure, and "fertility awareness" or natural family planning is among the least effective.[13]

B. Constitutional Rights

A series of Supreme Court opinions establish that part of the right to privacy is access to contraception. *Griswold*[14] struck down a ban on contraceptives that extended to married couples, holding that the restraint on contraceptive use in marriage is unconstitutional.[15] Not until seven years later did the Court extend this privilege to nonmarried individuals.[16] This marked a recognition that the right to privacy as to procreative choices does

---

PHYSICIAN e757, e758 (2012) ("The pill cleared the way for the introduction of an expanded range of hormone-based contraceptives."); *see also* Sonia Lopez et al., *Access to Contraception*, 18 GEO. J. GENDER & L. 439, 441–43 (2017) (describing modern, popular forms of contraceptives); *see generally Long-Acting Reversible Contraception Program*, AM. C. OBSTETRICIANS & GYNECOLOGISTS, https://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception (last visited April 17, 2018) (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

12. *See generally Contraception: How Effective Are Birth Control Methods?*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/reproductive health/contraception/index.htm (last updated Feb. 9, 2017) (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

13. *See Effectiveness of Family Planning Methods*, CENTERS FOR DISEASE CONTROL & PREVENTION, 1 (2011), https://www.cdc.gov/reproductivehealth/contra ception/unintendedpregnancy/pdf/Contraceptive_methods_508.pdf (showing that a method like spermicide is one of the least effective methods of birth control) (on file with the Washington & lee Journal of Civil Rights & Social Justice); *see also Fertility Awareness*, PLANNED PARENTHOOD, https://www.plannedparenthood.org/ learn/birth-control/fertility-awareness (last visited April 17, 2018), (explaining that fertility awareness methods "don't work as well as other types of birth control because they can be difficult to use") (on file with Washington & Lee Journal of Civil Rights & Social Justice).

14. *See* Griswold v. Connecticut, 381 U.S. 479, 485–86 (1965) (holding that a ban on the use of contraceptives in marriage violates the marital right to privacy).

15. *See id.* ("Would we allow the police to search the sacred precincts of marital bedrooms for telltale signs of the use of contraceptives? The very idea is repulsive to the notions of privacy surrounding the marriage relationship.").

16. *See* Eisenstadt v. Baird, 405 U.S. 438, 453 (1972) ("If under *Griswold* the distribution of contraceptives to married persons cannot be prohibited, a ban on distribution to unmarried persons would be equally impermissible.").

not lie in the married couple alone, but is also applicable to each individual.[17] By the end of the seventies, the Court recognized the right of minors to access contraceptives.[18] The case invalidated the New York law restricting distribution of contraceptives to minors; New York claimed that if unmarried teens had ready access to contraception and could reliably prevent pregnancy, then this would "lead to increased sexual activity among the young."[19] The Court dismissed the suggestion that it is appropriate to deter sexual activity by "increasing the hazards attendant on it."[20] This is the trilogy of cases, for my purposes, that set the stage for a discussion of access to contraception.

Another set of opinions on the right to abortion are similarly critical to women's control over their own fertility, and abortion remains women's last-ditch effort to hold the line on unwanted pregnancies.[21] This paper focuses on contraception, acknowledging that with more effective contraception, there would be less abortion, although the right to an abortion would still be necessary as an option to support access to contraception.[22]

---

17. *See id.* ("If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.").

18. *See* Carey v. Population Services, Int'l, 431 U.S. 678, 694 (1977) ("Since the State may not impose a blanket prohibition, or even a blanket requirement of parental consent, on the choice of a minor to terminate her pregnancy, the constitutionality of a blanket prohibition of the distribution of contraceptives to minors is a fortiori foreclosed."). Restrictions on minors' access to contraception varies by state. *See generally An Overview of Minors' Consent Laws*, GUTTMACHER INST., https://www.guttmacher.org/state-policy/explore/overview-minors-consent-law (last updated Apr. 1, 2018) (providing an overview of minors' access to contraception by state) (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

19. *Id.*

20. *See id.* ("The same argument, however, would support a ban on abortions for minors, or indeed support a prohibition on abortions, or access to contraceptives, for the unmarried, whose sexual activity is also against the public policy of many States. Yet, in each of these areas, the Court has rejected the argument . . . .").

21. June Carbone & Naomi Cahn, *The Triple System for Regulating Women's Reproduction*, 43 J.L. MED. & ETHICS 275, 278 (2015) [hereinafter *The Triple System for Regulating Women's Reproduction*] (describing abortion as "the ability to hold the line on the unplanned birth").

22. *See id.* at 278 ("Abortion rates are low and they have continued to fall, but they have done so overwhelmingly because this group has most unequivocally

Based as it is in traditional privacy jurisprudence, the right to contraception is protection against government interference with access rather than an affirmative right to guaranteed and publicly-financed availability. The result is a patchwork of payment systems.

C. Why Contraception Matters

We know access to contraception is important as a constitutional matter. More pragmatically, access to contraception is central to a range of issues such as women's employment and health and children's futures.

First, employment. Traditional "courtship" was based on an implied promise that if the woman got pregnant, the man would marry her (hence the term "shotgun marriage").[23] As women became able to control their own fertility, the implied promise (sex for potential marriage) was no longer necessary.[24] Once women gained greater access to the pill in the early 1960s, they were able to delay childbirth and marriage; they could thus invest in education and careers, avoiding mistimed childbearing and marriage.[25] As Claudia Goldin and Lawrence Katz observed, in a

---

embraced contraception."); *see also* Naomi Cahn & June Carbone, *Did the Pro-Life Movement Lead to More Single Moms?*, SLATE (Jan. 22, 2013), http://www.slate.com/articles/double_x/doublex/2013/01/did_the_pro_life_movement_lead_to_more_ single_moms.html (arguing that "in spite of conservative denials, contraception reduces abortions and early births . . . .") (on file with the Washington & Lee Journal of Civil Rights & Social Justice); *see generally* RED FAMILIES V. BLUE FAMILIES, *supra* note 2.

23. *See* George A. Akerlof et al., *An Analysis of Out-of-Wedlock Childbearing in the United States*, 111 Q.J. ECON. 277, 278 (1996) (explaining that until the early 1970s "it was the norm in premarital sexual relations that the partners would marry in the event of pregnancy").

24. *See* June Carbone & Naomi Cahn, *Family Classes: Rethinking Contraceptive Choice*, 20 U. FLA. J.L. & PUB. POL'Y 361, 368 (2009) ("Economists Akerlof, Yellin, and Katz observe that for traditionalists 'courtship' used to involve an implied promise: if the woman got pregnant, the man married her. As women gained the ability to control their own fertility through use of the pill and access to abortion, the implied promise disappeared.").

25. *See* Claudia Goldin & Lawrence F. Katz, *The Power of the Pill: Oral Contraceptives and Women's Career and Marriage Decisions,* 110 J. POL. ECON. 730, 731 (2002) (arguing that the pill "directly lowered the costs of engaging in long-term career investments by giving women far greater certainty regarding the pregnancy consequences of sex").

few short years, legal changes that made abortion legal and contraception available on college campuses had an immediate impact on the average age of marriage, overall fertility, and women's ability to attend professional and graduate schools.[26]

Indeed, the law and technological developments in healthcare have made an enormous difference in women's labor force participation. Women's labor force participation increased at least 8 percent just as a result of access to the pill.[27] Those women who were able to get access because of relaxed state laws were able to get even further ahead than women who had to wait for their states to catch up to the state of technology.[28] And the pill was responsible for about a third of the decrease in the gender wage gap by the year 2000.[29]

Second, health. Of course, contraceptive use decreases pregnancy-related mortality.[30] But birth control has benefits

---

26. *See id.* (explaining that the pill, "by encouraging the delay of marriage, created a 'thicker' marriage market for career women. Thus the pill may have enabled more women to opt for careers by indirectly lowering the cost of career investment").

27. *See* Martha J. Bailey, *More Power to the Pill: The Impact of Contraceptive Freedom on Women's Life Cycle Labor Supply*, 121 Q.J. ECON. 289, 295 (2006) ("The estimates suggest that access to the pill before age 21 reduced the likelihood of becoming a mother before age 22 by 14 to 18 percent and increased the extent of 26 to 30 year old women's labor-force participation by approximately 8 percent.").

28. *See id.* at 318 ("[C]onservative estimates suggest that from 1970 to 1990 early access to the pill can account for 3 of the 20 percentage point increase (14 percent) in labor-force participation rates and 67 of the 450 increase in annual hours worked (15 percent) among women ages 16 to 30 year olds.").

29. *See* Martha J. Bailey et al., *The Opt-In Revolution? Contraception and the Gender Gap in Wages*, NAT'L INST. HEALTH, July 2012, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3684076/pdf/nihms449365.pdf ("By their late forties, women with early access to the Pill earned a statistically significant hourly premium of 8 percent—enough to account for between one-third and half of the total hourly wage gains for these cohorts over their peers born a decade earlier.") (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

30. *See* Martha J. Bailey et al., *The Opt-In Revolution? Contraception and the Gender Gap in Wages*, 4 AM. JOURNAL: APPLIED ECON. 225, 227, July 2012, *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3684076/pdf/nihms449365.pdf ("By their late forties, women with early access to the Pill earned a statistically significant hourly premium of 8 percent—enough to account for between one-third and half of the total hourly wage gains for these cohorts over their peers born a decade earlier.") (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

beyond the maternal mortality rate; for example, IUD contraceptive devices may reduce a women's risk of cervical cancer by about a third.[31] So, in terms of actual impact on health, there are concrete measures of that. And spacing births lowers the risk of children being born prematurely.[32]

D. Breaking the Cycle of Poverty

Contraception can also help disrupt the cycle of poverty. Federally funded family planning programs are associated with significant reductions in child poverty rates, and later, with poverty rates in adulthood.[33] Individuals born after family planning funding are about five percent to ten percent less likely to live in poverty in childhood.[34] Children are healthier when they are spaced, and preventing teen birth helps girls graduate from high school, benefits children, and saves public money.[35]

---

31. *See* Victoria Cortessis et al., *Intrauterine Device Use and Cervical Cancer Risk: A Systematic Review and Meta-analysis,* 130 OBST. & GYNEC. 1226, 1233 (2017), *available at* https://journals.lww.com/greenjournal/Citation/2017/12000/Intrauterine_Device_Use_and_Cervical_Cancer_Risk_.7.aspx (concluding that there is "a robust inverse association between any use of an IUD and incident cervical cancer with overall incidence approximately 30% lower in women who reported ever using a device") (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

32. *See* E.A. DeFranco et al., *Influence of Interpregnancy Interval on Birth Timing*, 121 BJOG 1633, 1639 (2014), available at http://onlinelibrary.wiley.com/doi/10.1111/14710528.12891/abstract?systemMessage=Wiley+Online+Library+will+be+disrupted+Saturday,+7+June+from+10:00-15:00+BST+(05:00-10:00+EDT)+for+esse ntial+maintenance (concluding that "[i]mprovements in optimal birth spacing could result in overall reduction in preterm birth across the world, especially when focused on high risk women in whom short interpregnancy intervals occur most frequently") (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

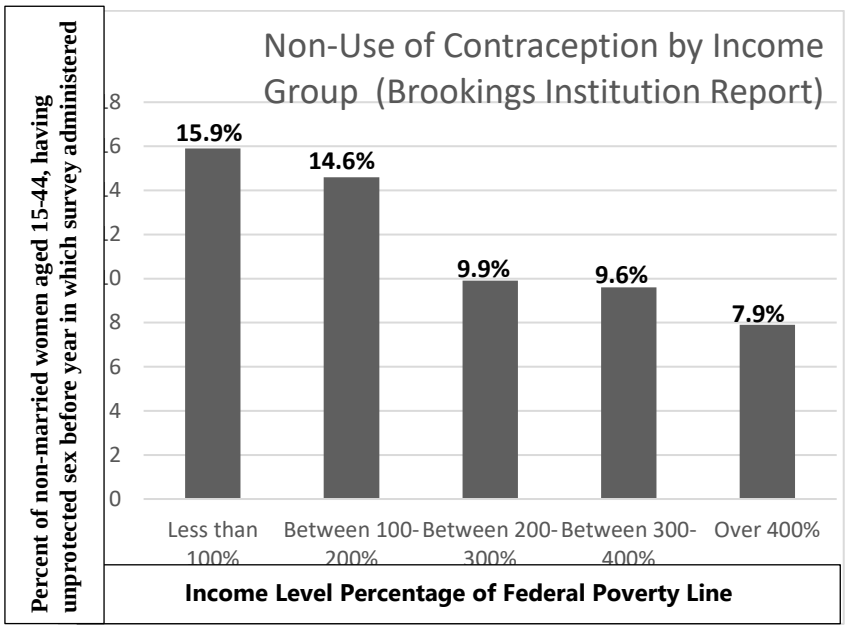
33. *See generally* Martha J. Bailey et al., *Do Family Planning Programs Decrease Poverty? Evidence from Public Census Data* 60(2) CESIFO ECON. STUD. 312 (Oct. 22, 2014), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4206087/; *see generally* Catherine Rampell, *Want to Fight Poverty? Expand Access to Contraception,* WASH. POST (Sept. 24, 2015), https://www.washingtonpost.com/opinions/a-powerful-tool-in-the-fight-against-poverty/2015/09/24/832c05fe-62f3-11e5-b38e-06883aacba64_story.html?utm_term=.d725e32c8274 (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

34. Bailey, *supra* note 33, at 318.

35. *See Reproductive Health: Teen Pregnancy*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/teenpregnancy/about/index.htm (last update

II. Dual System of Contraception Use

Figure 1[36]



In terms of using contraception, lower incomes are associated with higher rates of non-use of contraception, as the above chart shows.[37] The poorest women's rates of nonuse are about twice the rates of wealthier women. This is supported by qualitative data. In a study of nonmarital couples, the researchers found that middle class, college-educated couples were not only more likely to discuss contraception but also be consistent in their use of methods and

May 9, 2017) (explaining that teen pregnancy and childbearing "bring substantial social and economic costs through immediate and long-term impacts on teen parents and their children") (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

36. Richard V. Reeves & Joanna Venator, *Sex, Contraception, or Abortion? Explaining Class Gaps in Unintended Childbearing*, CTR. ON CHILD. & FAMILIES BROOKINGS fig. 2 (2015), *available at* https://www.brookings.edu/wp-content/uploads/2016/06/26_class_gaps_unintended_pregnancy.pdf (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

37. *Id.*

use more effective forms of contraception; their social scripts involved deferring childbearing.[38] By contrast, working-class couples (generally defined as those with only a high school diploma or some college), relied on less-effective methods and were more inconsistent in their use of contraception, often for reasons such as cost and access and forgetfulness.[39]

This leads me to pregnancy by intention status. On average, U.S. women expect to have two children.[40] That is average and does not predict what any individual family will in fact want to do. To accomplish the goal of having two children, a women will spend close to three years in the "pregnancy process," not including infertility. So essentially, if you are only spending three years being involved in the "pregnancy process," regardless of whether you are married or not, there is still a lot of time where you have to not be pregnant and that is where, of course, contraception comes in.

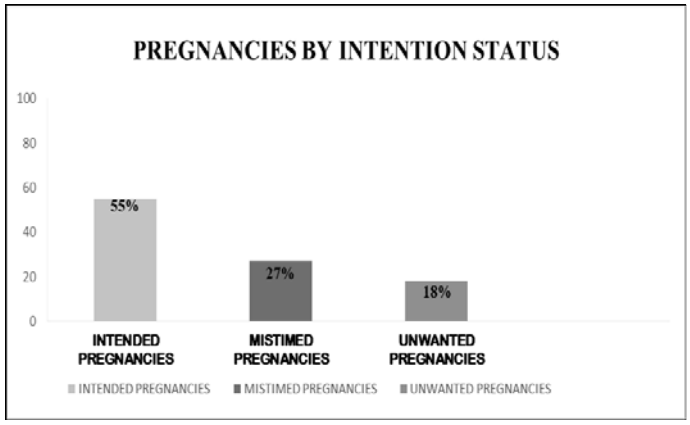
---

38. Sharon Sassler & Amanda J. Miller, "*We're Very Careful . . .": The Fertility Desires and Contraceptive Behaviors of Cohabiting Couples,* 63 FAM. REL. 538, 550 (2014) ("Middle-class cohabiting couples were, on the whole, utilizing contraceptives more consistently and chose more effective forms of preventing pregnancy . . . . Casual discussions of contraception occurred more routinely among the college educated, male partners frequently played a role in ensuring that birth control was taken regularly.").

39. *Id.*

40. Alexandra Sifferlin, *More American Women Want to Have Children*, TIME (Oct. 13, 2016), http://time.com/4528593/pregnancy-children-baby/ (on file with the Washington & Lee Journal of Civil Rights & Social Justice); *Unintended Pregnancy in the United States*, *supra* note 4.

Figure 2[41]



Source: Guttmacher Instit. Unintended Pregnancy in the United States (2016)[42]

Here, an unintended pregnancy was one that was either mistimed or unwanted. Teasing out the statistics, a large portion of the unintended pregnancies were mistimed rather than being unwanted—but there are still a lot of pregnancies that were unwanted. Unintended pregnancy rates are the highest among poor and low-income women.[43] Now the good news is there has been a decline in unintended pregnancies for all socio-economic groups, but notwithstanding that decrease, the unintended pregnancy rate varies dramatically by income. The bottom line is that wealthier women are far less likely to become pregnant before they are ready, with the rate increasing as the poverty level increases. Virtually all unintended pregnancies result from women who do not use contraception or use it inconsistently or incorrectly.[44] Further, planning a pregnancy is associated with

41. *Unintended Pregnancy in the United States*, *supra* note 4.

42. *Unintended Pregnancy in the United States*, *supra* note 4.

43. *Id.*; *see* Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008-2011*, 374 NEW ENGL. J. MED. 843, 849, 851 (2016) (concluding "the rate [of unintended pregnancies] among those who were unmarried but cohabiting was more than quadruple that among those who were married" and that "poor . . . women and girls continued to have much higher rates of unintended pregnancy than did whites and those with higher incomes").

44. *See Reproductive Health: Unintended Pregnancy Prevention*, *supra* note 1 ("Unintended pregnancy mainly results from not using contraception, or inconsistent or incorrect use of effective contraceptive methods.").

earlier initiation of prenatal care, more prenatal care visits, increased likelihood of breastfeeding and longer duration of breastfeeding.[45] Having one unintended birth is associated with perinatal depression[46] and with having more unintended births.[47] When a father reports that a pregnancy has been planned he may have increased odds of being involved both during the pregnancy and after birth.[48]

B. Knowing about Contraception: Sex Education

Using contraception means knowing about it. Adolescents learn about sexual-related topics from their parents, their schools, and their peers. Most teens have talked to their parents about some aspect of sex education.[49]

Sex education in the schools differs fundamentally between states with respect to whether it is comprehensive or focused on abstinence as well as whether it is required or permissive.[50] Thus,

---

45. *See* Shimrit Keddem et al., *The Association Between Pregnancy Intention and Breastfeeding*, 34 J. HUMAN LACT. 97, 98 (2017) (looking at the mother's intention as a factor in length of breastfeeding and at whether the father's intention to have a child predicted the mother was likely to breastfeed).

46. *See* Amanuel Alemu Abajobir et al., *A Systematic Review and Meta-Analysis of the Association Between Unintended Pregnancy and Perinatal Depression*, 192 J. AFFECTIVE DISORDERS 56, 57 (2016) (explaining how "[u]nintended pregnancies assessed through retrospective reports were found to be associated with maternal perinatal mental health including varying degrees of depressive disorders").

47. *See* Sowmya Rajin et al., *Trajectories of Unintended Fertility*, 36 POP. & RES. POL'Y REV. 903, 904 (2017) (focusing on the "on the association between an early unintended birth and a subsequent unintended birth").

48. *See* Milton Kotelchuck & Michael Lu, *Father's Role in Preconception Health*, 21 MATERNAL & CHILD HEAlth 2025, 2029–30 (2017) (explaining how improving men's preconception of health is important to ensure pregnancies are planned).

49. *See American Adolescents' Sources of Sexual Health Information*, GUTTMACHER INST. (Dec. 2017), https://www.guttmacher.org/fact-sheet/facts-american-teens-sources-information-about-sex (reporting that in 2011–2013, 70% of males and 78% of females aged 15–19 have talked with parents about how to say no to sex, methods of birth control, STDs, where to get birth control, how to prevent HIV infection, or how to use a condom) (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

50. *See* Rachel Rubenstein, Note, *Sex Education*: *Funding Facts, Not Fear*, 27 HEALTH MATRIX 525, 527 (2017) ("The most important distinction between states in the way they approach sex education is whether their statutory schemes

even states that do mandate that sex education be taught in schools, have a huge amount of variation in just what students learn. Many states—such as Maine and North Carolina and Tennessee—mandate sex education as part of the curriculum, but abstinence is stressed over more comprehensive sex education.[51] The problem is that for teens who are abstaining, it does not help to know that abstinence prevents pregnancy.[52] In fact, studies have repeatedly shown that comprehensive sex education means that young adults are actually less likely to have a teen pregnancy—and I mean there are all kinds of studies showing that if comprehensive sex education is required in schools, pregnancy is far less likely.[53] There is no definitive evidence that abstinence-only programs help delay sexual initiation or affect other behaviors, while comprehensive sex education—ironically—has been shown to delay sexual initiation and decrease risky behaviors, such as the lack of use of contraception. [54] Nonetheless, the federal

---

provide for comprehensive sexual education or abstinence-only education. Another vital distinction is whether sex education is mandatory, permitted, or not addressed specifically or at all.").

51. *See generally Sex and HIV Education*, GUTTMACHER INST. (Apr. 1, 2018), https://www.guttmacher.org/state-policy/explore/sex-and-hiv-education (on file with the Washington & Lee Journal of Civil Rights & Social Justice). Note that sex education is not mandated in Virginia. *Id.*

52. *See* Sarah McCammon, *Abstinence-Only Education is Ineffective and Unethical, Report Argues*, NPR (Aug. 23, 2017), https://www.npr.org/sections/health-shots/2017/08/23/545289168/abstinence-education-is-ineffective-and-unethical-report-argues ("Abstaining from sexual activity is a surefire way to prevent pregnancy and avoid sexually transmitted diseases. But programs advocating abstinence often fail to prevent young people from having sex . . . .") (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

53. *See* John S. Santelli et al., *Abstinence-Only-Until Marriage; An Updated Review of U.S. Policies and Program and Their Impac*t, 61 J. ADOL. HEALTH 273, 276 (2017) ("[T]he Centers for Disease Control and Prevention concluded that while CRR programs were an effective strategy for reducing adolescent pregnancy and STI/HIV among adolescents, 'no conclusions could be drawn on the effectiveness of group-based abstinence education.'"); *see generally* CMTY. PREVENTIVE SERVS. TASK FORCE, *Preventing HIV/AIDS, Other STIs, and Teen Pregnancy: Comprehensive Risk Reduction Interventions* 2 https://www.thecommunityguide.org/sites/default/files/assets/HIV-Pregnancy-Risk-Reduction.pdf (last updated Mar. 11, 2013) (on file with the Washington & Lee Journal of Civil rights & Social Justice).

54. *See* John Santelli, *Abstinence-Only Education Doesn't Work. We're Still Funding it*, WASH. POST (Aug. 21, 2017), https://www.washingtonpost.com/news/posteverything/wp/2017/08/21/abstinence-only-education-doesnt-work-were-still-funding-it/?nid&utm_term=.9cfe745453ab (citing a CDC study that concludes

government is increasing its funding for abstinence-only ("sexual risk avoidance") education.[55]

C. Explaining The Lack of Contraceptive Use

So why do women get pregnant when they are not intending to? For that, I am going to turn to Jennifer Barber, who is a sociologist at the University of Michigan who has done an incredible study called the Relationship, Dynamics and Social Life study.[56] Her research casts new light on the quality of the young women's relationships, the reasons why some relationships are more likely than others to lead to pregnancy, and the trajectories of fathers' involvement.[57]

She recruited close to one thousand teen women in Flint, Michigan—before the water crisis—and she asked them to keep diaries of their relationships, pregnancy, and intended status.[58] She then looked through the diaries and supplemented those with conversations with the women to try to find out much more about

---

that comprehensive programs have "favorable effects on multiple adolescent behaviors, including sexual initiation, number of sex partners, frequency of sexual activity, use of protection (condoms, oral contraceptives, or both), frequency of unprotected sexual activity, sexually transmitted infections and pregnancy") (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

55. *See id.* ("Buried among the many changes to health programs in this year's federal budget was an important one for young people. Congress added new funding for abstinence-only-until-marriage programs, bringing the annual total to $90 million.").

56. *Relationship Dynamics & Social Life Study*, UNIV. OF MICH. POPULATION STUD. CTR., https://rdsl.psc.isr. umich.edu (last visited April 17, 2018) (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

57. *See generally* Jennifer S. Barber et al., *Patterns of Contraceptive Consistency Among Young Adult Women in Southeastern Michigan: Longitudinal Findings Based on Journal Data*, 26 WOMEN'S HEALTH ISSUES 305 (2016); Jennifer S. Barber et al., *Participation in an Intensive Longitudinal Study with Weekly Web Surveys Over 2.5 Years*, 18 J. MED. INTERNET RES. 105 (2016); Jennifer S. Barber et al., *The Relationship Context of Young Pregnancies*, 35 LAW & INEQ. 175 (2017); *Jennifer* S. Barber et al., *Mediation Models of Pregnancy Desires and Unplanned Pregnancy in Young, Unmarried Women*, J. BIOSOC. SCI. 1–21 (2017).

58. *Patterns of Contraceptive Consistency Among Young Adult Women in Southeastern Michigan: Longitudinal Findings Based on Journal Data*, *supra* note 57.

their relationships.[59] Part of that was why these women—almost all of them did not want to become pregnant at the start of the study—why they became pregnant.[60] Not surprisingly, Jennifer reported that if either party desires a pregnancy, contraception use is particularly low—that makes sense.[61] Most of the women in the study reported no desire to get pregnant and a strong desire to avoid pregnancy at every stage over the course of the study, although approximately one-fifth did become pregnant.[62]

There were some significant differences between the women who became pregnant and those who did not. First, as can be seen in *Figure 1*, the demographics of the women who became pregnant showed that they were somewhat more disadvantaged than the women who did not.[63]

59. *Id.*

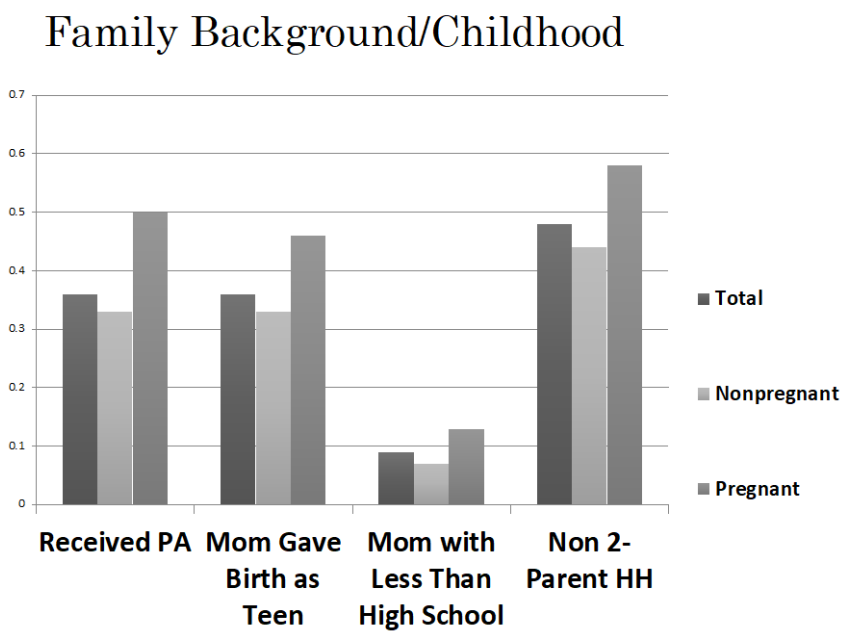
60. *Id.*

61. *Id.*

62. *The Relationship Context of Young Pregnancies*, *supra* note 57, at tbl.1; *see* Leslie Joan Harris, *Family Policy After the Fragile Families and Relationship Dynamics Studies*, 35 LAW & INEQ. 223, 229 (2017) ("At the beginning of the study, the women who became pregnant—like almost all the women in the study—strongly desired to avoid pregnancy.").

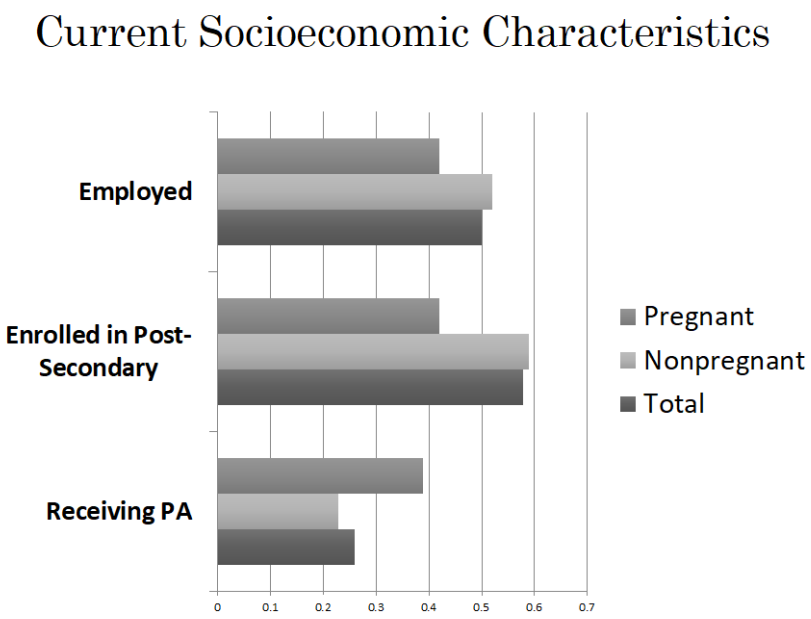
63. *See* June Carbone & Naomi Cahn, *Introduction*, 35 LAW & INEQ. 161, 172 (2017) ("By using weekly diaries to track young women before they became pregnant, the RDSL provides a new perspective on life circumstances and family formation among low-income women . . . . The most disadvantaged women . . . were more likely to become pregnant and to give birth . . . . younger . . ."); *see also* Harris, *supra* note 62, at 229 ("The study confirmed prior findings that young women who become pregnant were more disadvantaged than those who did not.").

Figure 3



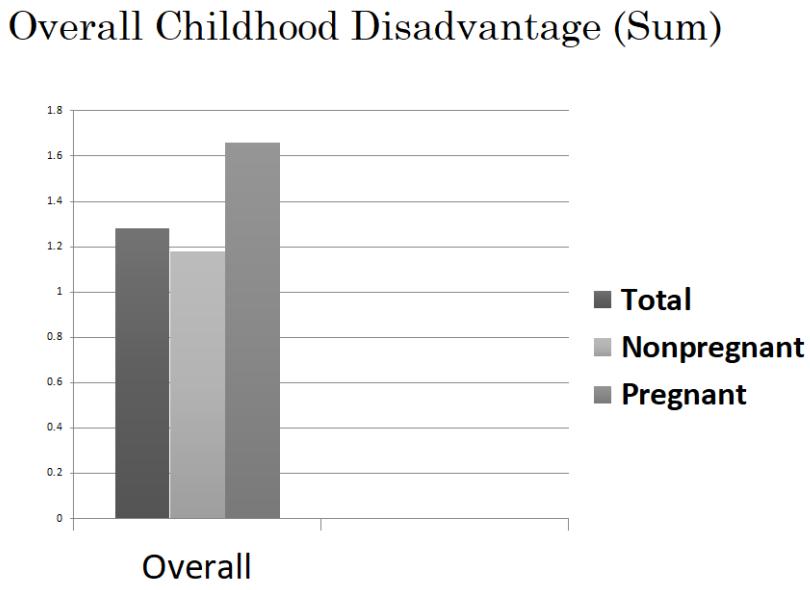
In terms of the family background of the women: the blue line represents un-pregnant women and the green line is pregnant women. What you can see is that the women who received public assistance, women who were children of teen moms, women who were children of moms with less than a high school education, as well as women who had not been raised in two parent households, were more likely than other women to get pregnant. So that breaks down some of the demographics of the unintended pregnancy rate.

Figure 4



Overall, in terms of their current socio-economic characteristics, women who were employed were less likely to be the pregnant ones. Women who were enrolled in post-secondary education were less likely to have gotten pregnant. So we are drawing a picture here between the relationship of getting pregnant and being of a lower socio-economic status—and the same thing with overall childhood disadvantage.

Figure 5



Second, the bigger differences involved the existence of violence in their relationship and their partners. The women who became pregnant experienced relationship violence at between two and three times the rate of those who did not become pregnant, and the violent men were more likely than non-violent men to have multiple children with multiple partners.[64] Moreover, where the women who became pregnant had more than one partner during the study period, the women's oldest and least educated partners were the most likely to father their pregnancies.[65] After the pregnancy occurred, the relationships often deteriorated, with couples breaking up or becoming less serious, and also becoming more violent.[66]

So there is a strong connection here with domestic violence, as well; women who got pregnant were in the most violent relationships. And while less than half of the non-pregnancy

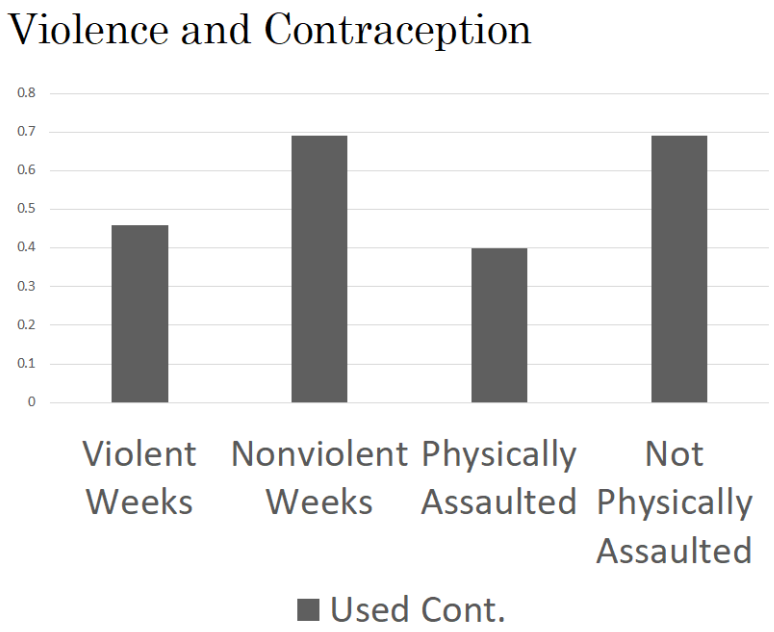
64. *The Relationship Context of Young Pregnancies*, *supra* note 57, at 192, 196–97.

65. *Id.* at 188–89, 195.

66. *Id.*

relationships included violence, three-quarters of the pregnancy relationships did involve violence.[67] There is a connection here with socio-economic status—there was much more domestic violence in relationships with a lower socio-economic status.

Figure 6



While correlation is not causation, it does seem to follow that non-use of contraception is more likely to result in pregnancy than is the consistent use of reliable contraception, and so the violence which [may have] caused the women to be less likely to use contraception seems related to a higher likelihood of becoming pregnant.

This study provides insight into explanations for teen pregnancy, based on violence and socioeconomic status. Further research can provide insight into adults' unwanted pregnancy and violence.

67. *Id.* at 196.

III. The Dual System of Legal Regulation

In the early 1960s, Jacobus tenBroek argued that families are regulated through "a dual system,"[68] with the systems differing in substance, purpose, and procedure.[69] One system focused on private arrangements and supported the families of those who were economically self-sufficient.[70] These families enjoy a measure of autonomy and are able to contract within or around mainstream norms, initiate their own court actions, and essentially determine the terms of their relationships themselves. tenBroek maintained, however, that a parallel second system existed, one imposed on those who sought public assistance.[71] In this second system, the state seeks to conserve public resources, imposing conditions on family rather than letting them choose their own terms.[72] Although tenBroek focused on traditional topics of family law, such as the marital relationship or child custody, his analysis applies to the legal regulation of contraception.[73]

Of course, the right to *use* contraception does not vary by wealth. Moreover, it is important to note that use of birth control at some point is nearly universal—ninety-nine percent of all sexually experienced women and ninety-eight percent of sexually

---

68. *See generally* Jacobus tenBroek, *California's Dual System of Family Law: Its Origin, Development, and Present Status*, 16 STAN. L. REV. 257 (1964) (Part I), 16 STAN. L. REV. 900 (1964) (Part II), 17 STAN. L. REV. 614 (1965) (Part III).

69. Jacobus tenBroek, *California's Dual System of Family Law: Its Origin, Development, and Present Status Part I*, 16 STAN. L. REV. 257, 257–58 (1964) [hereinafter tenBroeck (Part I)] (discussing the differences of the "two systems of family law in California").

70. *See id.* at 257–58 (saying that the private system "deals with the distribution of family funds, focuses on the rights and responsibilities of family members, and is civil, nonpolitical, and less penal").

71. *See id.* (saying that the public system "deals with expenditure and conservation of public funds and is heavily political and measurably penal").

72. *Id.*; *see* Leslie Harris, *The Basis for Legal Parentage and the Clash Between Custody and Child Support*, 42 IND. L. REV. 611, 612–13 (2009) (noting that tenBroek "described a public system of family law that applies principally to poor people, especially recipients of public benefits, and focuses on conservation of public funds"); *see generally* RED FAMILIES V. BLUE FAMILIES, *supra* note 2.

73. *Cf.* Tanya Brito, *The Welfarization of Family Law*, 48 U. KAN. L. REV. 229, 238–50 (2000) (comparing and applying tenBroek's analysis on family law to childbearing and childrearing).

experienced Catholic women have used it at some point in their lives.[74]

Nonetheless, the financial ability to access contraception, and the differing systems for payment, show a class divergence. Poor women access contraception through the state-federal partnership of Medicaid and federally funded family planning care, programs which vary in their coverage and their conditions of eligibility;[75] women who are employed have access to private insurance and are less dependent on what a state chooses to provide. A 2010 survey (pre-Affordable Care Act) found that more than one-third of female voters had struggled to afford prescription birth control at some point in their lives and, as a result, had used birth control inconsistently.[76] At that point, birth control payments constituted

---

74. *Contraceptive Use in the United States: Who Needs Contraceptives*?, GUTTMACHER INST. (Sept. 2016), https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states (on file with the Washington & Lee Journal of Civil Rights & Social Justice). Rates over time vary. Three out of every five women are likely to be using contraceptives at any given point. *See* CTRS. FOR DISEASE CONTROL & PREVENTION, CURRENT CONTRACEPTIVE USE IN THE UNITED STATES 2006-2010, AND CHANGES IN PATTERNS OF USE SINCE 1995 (Oct. 2012), https://www.cdc.gov/nchs/data/nhsr/nhsr060.pdf ("Overall in 2006–2010, 62% of women aged 15–44 were using a method of contraception in the month of interview and 38% were not . . . .") (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

75. *See Publicly Funded Family Planning Services in the United States*, GUTTMACHER INST. (Sept. 2016), https://www.guttmacher.org/fact-sheet/publicly-funded-family-planning-services-united-states ("Medicaid accounted for 75% of 2010 expenditures on family planning, state appropriations accounted for 12% and Title X for 10%.") (on file with the Washington & Lee Journal of Civil Rights & Social Justice); Jenna Walls et al., *Medicaid Coverage of Family Planning Benefits: Results from a State Survey*, HENRY J. KAISER FAM. FOUND. (2016), https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-results-from-a-state-survey/ ("Family planning services are "mandatory" benefits under Medicaid and must be provided to individuals of childbearing age free of cost-sharing. There is, however, no formal federal definition of "family planning," which has given states considerable discretion to determine the specific services covered under this benefit.").

76. *See* Shilpa Padke, *Rhetoric vs. Reality: Why Access to Contraception Matters to Women*, CTR. FOR AM. PROGRESS (Nov. 15, 2017), https://www.americanprogress.org/issues/women/reports/2017/11/15/442808/rhetoric-vs-reality-access-contraception-matters-women/ ("Needing birth control and being able to afford it, however, are different issues. One in three women ages 18 to 44 say that they could not pay more than $10 per month for birth control if they had to buy it today.") (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

approximately 30–44% total out-of-pocket expenses for health care.[77]

In terms of federal funding for contraception outside of Medicaid, Title X is the only federal program dedicated solely to the delivery of family planning and related healthcare.[78] It started in the early 1970s under, of all Presidents, President Nixon.[79] It has been in the news over the past few months because of changes to it during the current administration.

Title X provides contraceptive supplies and information based on income, with priority given to people from low-income families.[80] It also provides sex education and counseling, cancer

---

77. *Id.*

78. *See* Usha Ranji et al., *Financing Family Planning Services for Low-Income Women: The Role of Public Programs*, HENRY J. KAISER FAM. FOUND. (May 11, 2017), https://www.kff.org/womens-health-policy/issue-brief/financing-family-planning-services-for-low-income-women-the-role-of-public-programs/ ("The Title X National Family Planning Program, a federal block grant administered by the HHS Office of Population Affairs (OPA), is the only federal program specifically dedicated to supporting the delivery of family planning care.") (on file with the Washington & Lee Journal of Civil Rights & Social Justice). Note that these funds are not available to programs if abortion is a method of family planning. *See* 42 C.F.R. § 59.5(a)(5) (2000) ("Each project supported under this part must . . . [n]ot provide abortion as a method of family planning."). Indeed, since the enactment of the Hyde Amendment in 1976, there is no federal Medicaid funding of abortion, except in three narrow circumstances. *See Medicaid Funding of Abortion*, GUTTMACHER INST. (Feb. 2018), https://www.guttmacher.org/evidence-you-can-use/medicaid-funding-abortion ("All state Medicaid programs must cover abortions under these circumstances; however, states have the option to cover other abortions using their own funds.") (on file with the Washington & Lee Journal of Civil Rights & Social Justice). The dual class-based system of access to contraception exists when it comes to funding for abortion. *Cf.* NAT'L WOMEN'S L. CTR., STATE LAWS REGULATING INSURANCE COVERAGE OF ABORTION HAVE SERIOUS CONSEQUENCES FOR WOMEN'S EQUALITY, HEALTH, AND ECONOMIC STABILITY 1 (Dec. 2017), *available at* https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/12/50-State-Insurance-Coverage-of-Abortion.pdf (explaining how "accessing reproductive health care can be costly, making insurance coverage critical for women who are seeking an abortion. Without coverage of abortion, many women are forced to forgo care—threatening both their physical and economic health") (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

79. *40 Years Ago: Title X, The Family Planning Services and Population Research Act of 1970*, NAT'L LOW INCOME HOUSING COALITION (Oct. 6, 2014), http://nlihc.org/article/40-years-ago-title-x-family-planning-services-and-population-research-act-1970.

80. *See* OFF. OF POPULATION AFF., PROGRAM REQUIREMENTS FOR TITLE X FUNDED FAMILY PLANNING PROJECTS 5 (Apr. 2014), https://www.hhs.gov/opa/sites/default/files/ogc-cleared-final-april.pdf (explaining that the Title X Family

screenings, and STD and HIV screenings and counseling, and funding for clinic infrastructure.[81] There are, of course, other sources of federal funding for family planning. Moreover, almost one-half of the births that occur each year are paid for by Medicaid.[82] Total public expenditures on unintended pregnancies nationwide were estimated to be over twenty billion dollars.[83]

In terms of some of the Trump changes, the Department of Health and Human Services issued its annual notice concerning anticipated availability of funds for family planning service grants in February 2018.[84] The prior year's notice mentioned "natural family planning methods" once and "contraceptive" nine times; the 2018 notice mentioned natural family planning methods five times, but never used the term "contraceptive."[85] The 2018 notice listed, as its second priority, "activities that promote positive family relationships for the purpose of increasing family participation in family planning,"[86] while this did not appear in the

---

Planning Program is "designed to provide contraceptive supplies and information to all who want and need them, with priority given to persons from low-income families") (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

81. *Id.*

82. Kathy Gifford et al., *Medicaid Coverage of Pregnancy and Perinatal Benefits: Results from a State Survey*, HENRY J. KAISER FAM. FOUND. (Apr. 27, 2017), https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-pregnancy-and-perinatal-benefits-results-from-a-state-survey/ (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

83. Adam Sonfield & Kathryn Kost, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, GUTTMACHER INST. (Feb. 2015), https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

84. *See generally* U.S. DEP'T OF HEALTH & HUMAN SERV., ANNOUNCEMENT OF ANTICIPATED AVAILABILITY OF FUNDS FOR FAMILY PLANNING SERVICES GRANTS (Feb. 23, 2018), https://www.hhs.gov/opa/sites/default/files/FY18%20Title%20X%20Services%20FOA_Final_Signed.pdf (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

85. *See generally id.*; *see also generally* U.S. DEP'T OF HEALTH & HUMAN SERVS., ANNOUNCEMENT OF ANTICIPATED AVAILABILITY OF FUNDS FOR FAMILY PLANNING SERVICES GRANTS (Oct. 5., 2016), https://www.hhs.gov/opa/sites/default/files/FY-17-Title-X-FOA-New-Competitions.pdf (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

86. This does sound positive—except it now means that family planning is not focused on the individual seeking the services. *See* Haberkorn, *supra* note 12 ("The application stresses natural family planning methods and eliminates the

prior year's notice. These changes suggest that women's health and contraceptive choices are no longer the primary focus of family planning, and that both abstinence and less effective contraceptive methods are assuming greater importance.

A second change is in Medicaid. Medicaid is a state/federal partnership, and states have sought to impose additional requirements on recipients.

For wealthier women, the Affordable Care Act contraceptive mandate has been critical. This made contraceptive coverage a national policy by requiring most—and various Supreme Court opinions have cut back on this a bit—private health insurance plans to provide coverage for a broad range of preventative services, including FDA prescription contraceptives and other services for women, and without cost-sharing for the method itself.[87] Since the implementation of the ACA's contraceptive coverage provision, fewer women are paying out of pocket for contraceptives. This does not mean there are no costs; for example, there are co-pays for office visits.[88] The number of reproductive-age women who have spent out-of-pocket for contraceptives has declined dramatically, and half of all women receive their coverage through their employers (or their spouse's employer).[89]

Obama administration's focus on all forms of contraception—changes that trouble Title X grantees.").

87. *See Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2759 (2014) (holding that regulations that require closely held corporations to provide methods of contraception that violate sincerely held religious beliefs of the companies violate the Religious Freedom Restoration Act); *see also* Laurie Sobel et al., *Private Insurance Coverage of Contraception*, HENRY J. KAISER FAM. FOUND. (2016), https://www.kff.org/womens-health-policy/issue-brief/private-insurance-coverage-of-contraception/ ("In 2012, all new private plans were required to cover, without cost-sharing, the full range of contraceptives and services approved by the Food and Drug Administration (FDA) as prescribed for women.") (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

88. *See* Jamila Taylor & Nikita Mhatre, Contraceptive Coverage Under the Affordable Care Act, CTR. FOR AM. PROGRESS (Oct. 6, 2017), https://www.americanprogress.org/issues/women/news/2017/10/06/440492/contraceptive-coverage-affordable-care-act/ (laying out birth control costs—out-of-pocket costs and total potential cost without insurance) (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

89. *See* Sobel et al., *supra* note 87 ("For example, the share of reproductive age women experiencing out-of-pocket spending on oral contraceptive pills declined from 20.9% in 2012 to 3.6% in 2014. This decline accounts for nearly two-thirds (63%) of the drop in out-of-pocket spending on retail drugs during this time

A major change affecting middle-class women concerns which employers are required to offer which types of contraceptive coverage. Previously under the Obama regulation relating to contraceptive coverage there was an exception essentially for houses of worship that had religious objections to contraception such that they were not required to guarantee coverage to contraception.[90] Rather than an exemption, religiously affiliated nonprofits and closely held for-profit corporations could choose an "accommodation," whereby they did not need to pay for contraception coverage, but their employees would have coverage because the insurer would pay.[91] That has now been expanded, so the latter group of institutions is now eligible for an exemption if they have religious beliefs or moral convictions against paying for contraception, and publicly traded for-profit companies that have religious objections to covering various forms of contraception.[92] This is a huge change and huge expansion—we are still not sure just how large it is or will be.

I have done work on contraception in the context of various projects with Professor June Carbone, who teaches at the University of Minnesota. We have talked about red family strategies versus blue family strategies and how the ability to delay child-bearing makes a huge difference, as I said at the beginning of this talk, to the health of families and to women's ability to be in the workforce.[93] In terms of solutions (this is a

---

period.").

90. Robert Pear, *U.S. Clarifies Policy on Birth Control for Religious Groups*, N.Y. TIMES (Mar. 16, 2012), https://www.nytimes.com/2012/03/17/health/policy/obama-administration-says-birth-control-mandate-applies-to-religious-groups-that-insure-themselves.html.

91. *See id.* ("President Obama had previously announced what he described as an "accommodation" for religiously affiliated organizations.").

92. *See Trump Administration Issues Rules Protecting the Conscience Rights of All Americans*, U.S. DEP'T HEALTH & HUMAN SERV. (Oct. 6, 2017), https://www.hhs.gov/about/news/2017/10/06/trump-administration-issues-rules-protecting-the-conscience-rights-of-all-americans.html (announcing two rules: one that exempts entities with sincerely held religious beliefs against providing health insurance that covers contraceptive services, and one that exempts organizations and small businesses that have objections on the basis of moral convict not based in religious belief) (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

93. *See, e.g.*, *The Triple System for Regulating Women's Reproduction*, *supra* note 21, at 275 (explaining that the "Blue Family" system "emphasizes the importance of women's as well as men's workforce participation, relatively

matter of updating our conclusions with respect to contraception from *Red Families v. Blue Families*), they involve supporting comprehensive sex education, continuing to provide widespread and free (or inexpensive) access to contraception, and provide caring for children who are born regardless of whether they are planned or unplanned.

This gets to what I have already foreshadowed, and what June Carbone and I advocate: the concept of contraception as a system. The Dutch do this: they do not actually teach kindergarteners about contraception, per se, but they try to teach healthy behaviors.[94] In doing so, contraception becomes a system; it becomes routine; it becomes something that is talked about. Given that the best way to reduce the risk of unintended pregnancy is to use effective birth control correctly and consistently, frank and honest discussion about contraception and healthy relationships provides an important basis.

Indeed, statistics support the need for consistent and correct use of birth control. As a 2017 study found, of the women who are at risk for unintended pregnancy, the 68 percent of those women who used contraception regularly accounted for 5 percent of unintended pregnancies.[95] So a woman who has access to contraception and uses it is much less likely to get pregnant. The 18 percent of women who are at risk and who are inconsistent in their use of contraceptives accounted for 41 percent of unintended pregnancies.[96] The 14 percent at risk who did not use contraceptives at all are responsible for 54 percent of the unwanted pregnancies.[97] This turns on pregnancy prevention programs and sex education, as I mentioned earlier. Comprehensive sex education (and access) make a difference.

---

egalitarian gender roles, and the delay of family formation until both prospective parents are emotionally and financially ready"); *see generally* RED FAMILIES V. BLUE FAMILIES, supra note 2.

94. *See generally* Peggy Orenstein, *Worried About Your Teenage Daughter? Move to the Netherlands*, L.A. TIMES (Apr. 6, 2016), http://www.latimes.com/opinion/op-ed/la-oe-0410-orenstein-girls-sex-dutch-20160410-story.html (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

95. *Unintended Pregnancy in the United States*, *supra* note 4.

96. *Id.*

97. *Id.*

Pregnancy and birth are a significant contributor to high school dropout rates among girls.[98] Only 53 percent of teen mothers actually receive a high school diploma by the age of twenty-two, compared to 90 percent of women who do not give birth during adolescence.[99] That is almost double—if a girl or woman does not give birth as a teen, she is almost twice as likely to finish high school. There are also huge implications for poverty rates because children of teenage mothers are more likely to have lower school achievements and to drop out of high school, to give birth as a teenager themselves, and to face unemployment as an adult. So there are cyclical consequences of teen pregnancy.[100]

One of the questions about the discussion so far is why the focus on women rather than (or in addition to) the men who are involved in creating the pregnancy? The simple answer is that we know much more about the women than we do about the men who have gotten them pregnant, and that is why I'm focusing on them. This is a huge research need. It is harder to track down the men for obvious reasons—they are not (necessarily) going to accompany the women to maternity clinics, they are not giving birth. This is an important research gap that needs to be filled.[101]

---

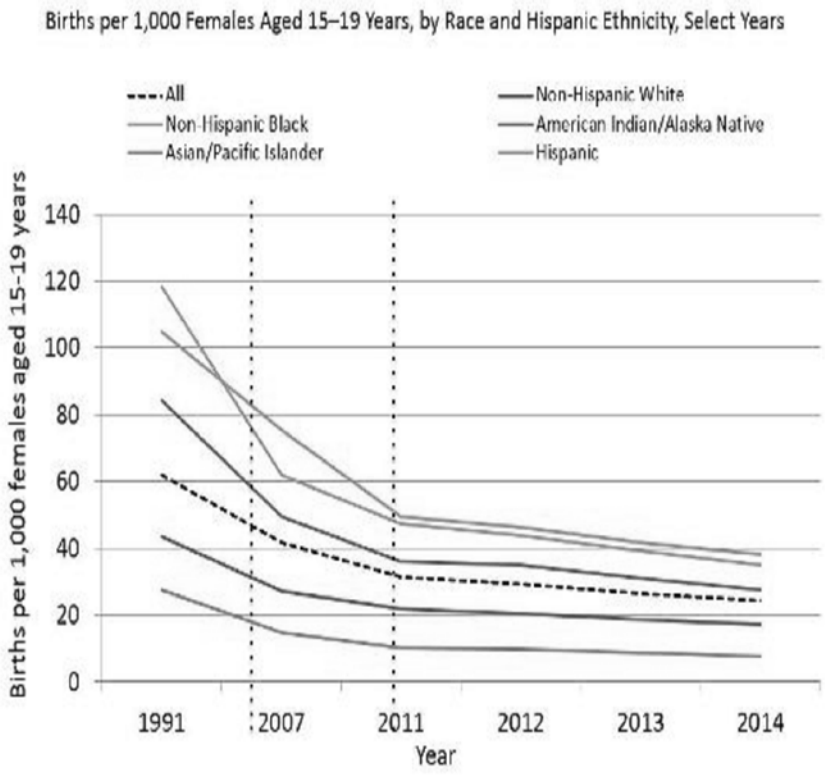
98. *About Teen Pregnancy: Teen Pregnancy in the United States*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/teenpregnancy/about/index.htm (last updated May 9, 2017) (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

99. Jennifer Manlove & Hannah Lantos, *Data Point: Half of 20- to 29-year-old Women Who Gave Birth in Their Teens Have a High School Diploma*, CHILDTRENDS (Jan. 11, 2018), https://www.childtrends.org/half-20-29-year-old-women-gave-birth-teens-high-school-diploma/ (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

100. *See About Teen Pregnancy*, *supra* note 98 ("The children of teenage mothers are more likely to have lower school achievement and to drop out of high school, have more health problems, be incarcerated at some time during adolescence, give birth as a teenager, and face unemployment as a young adult.").

101. For information about some of these men, see KATHRYN EDIN & TIMOTHY J. NELSON, DOING THE BEST I CAN: FATHERHOOD IN THE INNER CITY (2013); ANDREW L. YARROW, MAN OUT: MEN ON THE SIDELINES OF AMERICAN LIFE (forthcoming Sept. 11, 2018).

Figure 7



This chart shows the decline in teen birth rates nationally.[102] Some part of this decline is due to abstinence[103] but "[improvements in contraceptive use appear to be primary proximal determinants of declines in adolescent pregnancy and birth rates."[104]

---

102. *About Teen Pregnancy: Teen Pregnancy in the United States*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/teenpregnancy/about/index.htm (last updated May 9, 2017) (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

103. *See id.* ("Although reasons for the declines are not totally clear, evidence suggests these declines are due to more teens abstaining from sexual activity, and more teens who are sexually active using birth control than in previous years.").

104. Laura Lindberg et al., *Understanding the Decline in Adolescent Fertility*

Two studies, one in Colorado and one at Washington University in St. Louis, have used private funding to study how access to long acting reversible contraceptives (LARC) can affect pregnancy and abortion rates. The St. Louis CHOICE project recruited women through clinics and various forms of media and offered them a choice of contraceptive methods at no cost.[105] Of the 1404 women who enrolled, 72 percent chose a LARC method.[106] The teen pregnancy and abortion rates for study participants were approximately five times lower than national averages.[107]

In Colorado, the Family Planning Initiative improved access to long-acting reversible contraceptives.[108] In 2009, the Initiative received private funding to start a program at family planning clinics in counties with virtually all (95 percent) of the state's population.[109] The program had a significant impact on types of contraception used, pregnancy, and abortion rates. First, the LARC usage increased substantially. Second, the birth rate among fifteen to nineteen-year-olds in Colorado was virtually cut in half (the national rate also declined, but not as dramatically).[110] Third,

---

in the United States, 2007–2012, 59 J. ADOLESCENT HEALTH 577, 577 (2016).

105. Gina M. Secura et al*., Provision of No-Cost, Long-Acting Contraception and Teenage Pregnancy*, 371 NEW ENGL. J. MED. 1316, 1316 (2014).

106. Gina M. Secura et al., *The Contraceptive CHOICE Project: Reducing Barriers to Long-acting Reversible Contraception,* 203 AM. J. OB. & GYN. 115.e1, Tbl. 1 (2010).

107. Amanda Marcotte, *St. Louis Study Confirms that IUDs are the Key to Lowering Teen Pregnancy Rates*, SLATE (Oct. 2, 2014), http://www.slate.com/blogs/xx_factor/2014/10/02/st_louis_choice_project_provide_free_iuds_and_no_one_gets_pregnant.html (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

108. *See generally* COLO. DEP'T. PUB. HEALTH & ENV'T, TAKING THE UNINTENDED OUT OF PREGNANCY: COLORADO'S SUCCESS WITH LONG-ACTING REVERSIBLE CONTRACEPTION (Jan. 2017), https://www.colorado.gov/pacific/sites/default/files/PSD_TitleX3_CFPI-Report.pdf (on file with the Washington & Lee Journal of Civil Rights & Social Justice); *see generally* Sue Rickets et al., *Game Change in Colorado: Widespread Use of Long-Acting Reversible Contraceptives and Rapid Decline in Births Among Young, Low-Income Women*, 46 PERSP. ON SEXUAL & REPROD. HEALTH 125 (2014).

109. *See generally* Dr. Larry Wolk, Colorado Family Planning Initiative: A Colorado Success Story, Remarks at the Colo. Dep't Pub. Health & Env't (Dec. 2015) (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

110. TAKING THE UNINTENDED OUT OF PREGNANCY: COLORADO'S SUCCESS WITH LONG-ACTING REVERSIBLE CONTRACEPTION, *supra* note 108, at 21.

the abortion rate fell by 34 percent.[111] Fourth, the unintended pregnancy rate decreased by 40 percent.[112] Though not all of these declines were due to LARC use, the researchers estimate that, for example, at least half of the decline of the birth rates among these age groups were due to the Initiative.[113] The researchers also noted that the declines were not due to changes in sexual behavior.[114]

It was not just that they were able to get access—this also actually impacted the abortion rate. That is, effective, reliable, and free contraception lowered the abortion rate. Other states have sought to use some of the Colorado techniques.[115]

IV. Conclusion

Women who plan their pregnancies create greater economic stability for themselves and their families.[116] Interestingly enough, college-educated women who have unintended pregnancies are actually more likely to get abortions than poor women, but college-educated women are much less likely to have an unintended pregnancy in the first place.[117] In terms of the impact on children,

---

111. Rickets et al., supra note 108, at 125.

112. TAKING THE UNINTENDED OUT OF PREGNANCY, *supra* note 108, at 26.

113. *Id.* at xi.

114. *See* Priscilla J. Smith, *Contraceptive Comstockery: Reasoning from Immorality to Illness in the Twenty-First Century*, 47 CONN. L. REV. 971, 1021 (2015) ("Study authors were also able to rule out alternative explanations for the drop in fertility rates, such as the potential that the rate of sexual activity decreased.").

115. *See Stateline: A Pregnancy Prevention Breakthrough*, PEW CHARITABLE TR. (Feb. 12, 2015), http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/2/12/a-pregnancy-prevention-breakthrough ("The abortion rate among teens in the project also dipped to 10 per 1,000 compared to a national average of 42 per 1,000.") (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

116. *See* AM. CONGRESS OF OBSTETRICIANS & GYNECOLOGISTS, FACTS ARE IMPORTANT: CONTRACEPTIVE CARE IS GOOD WOMEN'S HEALTH CARE 2 (2017), https://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/FactsAreImportantContraAccess.pdf?dmc=1&ts=20180227T1835372893 ("The ability to plan a pregnancy increases engagement of women in the workforce and improves economic stability for women and their families.") (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

117. *See* Finer & Zolna, *supra* note 43, at 849 ("[P]oor and less-educated females were less likely to have induced abortions to end unintended pregnancies.").

there are different success rates based on whether children are intended children versus whether they are mistimed or unwanted children.[118] It is not hugely different, but children who are intended by their parents generally do better throughout a range of different measures.

Ultimately, the real consensus solution here is: support education, bring back jobs for blue collar workers, increase stability (not just income), strengthen the social safety net, and then—in case the message isn't clear enough—support contraception. That will help in rebuilding communities.

118. *See generally* Sawhill et al., *supra* note 1.