FEMINIST MAJORITY FOUNDATION
FEMINIST CAMPUS
WORLD'S LARGEST FEMINIST STUDENT NETWORK

Campaign for Birth Control Access

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THE BASICS

In the US, there are 61 million women in their childbearing years (15-44). Roughly 70% of them are sexually active and at risk of an unintended pregnancy. Of those women, more than 99% have used some form of birth control to prevent an unintended pregnancy.[1] Contraceptive use is common among women of all religious denominations. 89% percent of at-risk Catholics and 90% of at-risk Protestants currently use a contraceptive method. Among sexually active religious women, 99% of Catholics and Protestants have ever used some form of contraception.[2] However, the most marginalized groups—women of color, queer/bisexual women, transgender men, and gender non-conforming people—do not fully share in this access equally, which is why efforts to expand access to birth control and prenatal health resources must be grounded in trans-inclusive antipoverty and racial justice efforts.

BENEFITS OF BIRTH CONTROL USAGE

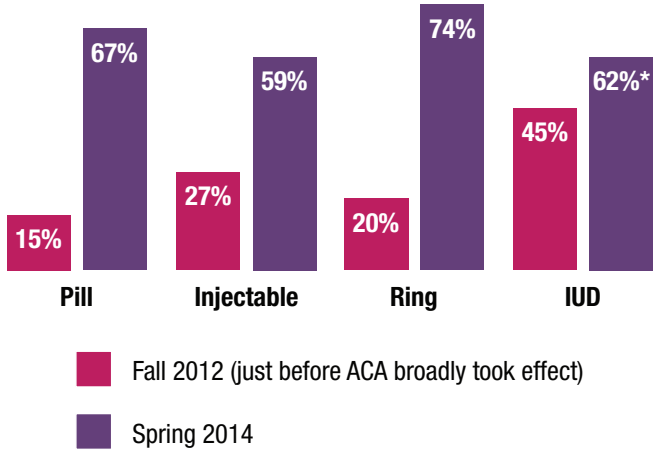
Women and couples use contraceptives to prevent pregnancies, have healthier pregnancies, to help plan and space births, and to achieve their desired family size. For people who choose to have children, deciding when to do so has well-documented health benefits for mothers, newborns, families and communities. Pregnancies that occur too early or too late in life, or are spaced too closely, negatively affect maternal health and increase the risk of low birth weight in infants.

The ability to prevent, delay, and space childbearing is crucial to women's social and economic advancement. The ability to obtain and effectively use contraceptives has a positive impact on women's education and professional careers, as well as on outcomes related to income, family stability, mental health and happiness, and children's well-being. Furthermore, every $1.00 invested in preventing unintended pregnancies saved $7.09 in Medicaid expenditures that would otherwise have been needed to pay the medical costs of pregnancy, delivery and early childhood care.[3] Many hormonal methods—the pill, vaginal ring, patch, implant and IUD—offer countless health benefits in addition to contraceptive effectiveness, such as treatment for ovarian cysts, endometriosis, menstrual bleeding, menstrual pain, and acne.

1. Daniels K, Daugherty J and Jones J, Current contraceptive status among women aged 15–44: United States, 2011–2013, National Health Statistics Reports, 2014, No. 173, http://www.cdc.gov/nchs/data/databriefs/db173.pdf.
2. Jones RK and Dreweke J, Countering Conventional Wisdom: New Evidence on Religion and Contraceptive Use, New York: Guttmacher Institute, 2011.
3. Frost, JJ, et al., Return on investment: a fuller assessment of the benefits and cost savings of the US publicly funded family planning program, Milbank Quarterly, 2014, 92(4):667–720.

OUT OF POCKET COSTS

The percentage of privately insured women who paid $0 out of pocket for each birth control method.



*** based on combined data for spring 2013, fall 2013, and spring 2014 because the number of IUD users surveyed was small.**

Source: Guttmacher Institute, "New Study Shows Privately Insured Women Increasingly Able to Obtain Prescription Contraceptive Methods with No Out-Of-Pocket Costs" accessed 8 March 2018 at http://www.guttmacher.org/media/nr/2014/09/18/

INCREASING ACCESS TO BIRTH CONTROL

Under the preventive care package of the Affordable Care Act (ACA), health insurance plans are required to cover FDA-approved contraceptives, without co-pays or deductibles. The birth control benefit went into effect for most private insurance plans as of January 2013 and allowed millions of people to access birth control for free, but there are some exceptions. Some older health insurance plans are considered "grandfathered" plans and remain unaltered by the birth control policy until they lose their protected status over the next few years, meaning these plans are not required to provide free birth control. As of 2016, 23% of individuals were covered by grandfathered employer-sponsored health plans. Your health plan benefits administrator can tell you whether you are covered by a grandfathered plan. If so, you can choose to purchase insurance on the ACA marketplace.

In October 2017, the Trump Administration made it easier for employers to exclude contraceptive coverage from any health plan they offer to employees and their dependents. One regulation allows any employer—nonprofit or for-profit—to exclude some or all contraceptive methods and services from the health plans it sponsors if the employer has religious objections. Another regulation allows employers with moral

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objections to do the same, any employer that is not a publicly traded company. Enforcement of these regulations has been blocked by the courts.

In most cases, pharmacies and insurance companies should not be charging women for contraceptives. Health plans, however, may be able to charge co-pays for a brand name drug if there is a medically appropriate, generic version of your birth control available. If there is no generic version available or if the generic version would be medically inappropriate then the plan must waive the cost.

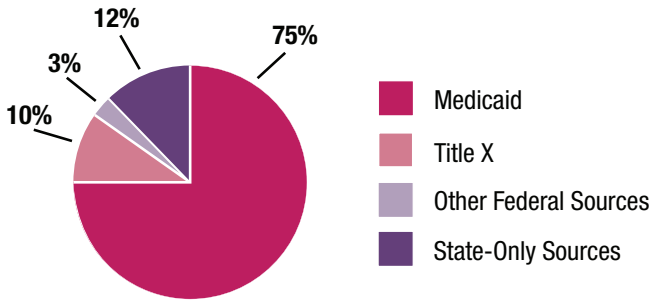
Churches and houses of worship are totally exempted from having to provide birth control coverage to their employees or their dependents. Under a federal accommodation, religiously affiliated non-profit organizations, such as colleges and hospitals, can refuse to pay for birth control coverage, but a student or employee can still access birth control at no cost to them. In these cases, the insurance company or third party administrator pays for the coverage. In 2014, in the highly publicized "Hobby Lobby Case," the Supreme Court ruled that closely-held, for-profit companies can also opt out of paying for this coverage if it would violate the company's sincerely-held religious beliefs.

Several religiously affiliated non-profits have challenged the accommodation in federal court. The non-profits seeking to deny employees access to birth control argue that the requirement to fill out a one-page form, or otherwise notify the Department of Health and Human Services, to receive the accommodation places a substantial burden on their exercise of religion and violates the Religious Freedom Restoration Act (RFRA). Eight federal appeals courts have ruled against the non-profits. Only one court, the Eighth Circuit Court of Appeals, has sided with them.

The Supreme Court proposed a settlement of the dispute which would have employers tell their insurance companies that they did not want contraceptive coverage in their plans, and then the insurance companies would offer contraceptive coverage to the employees separately. This plan would remove the 'burden' of employers asking for accommodation, but still allow employees to receive coverage. After said proposal, the Supreme Court sent all cases entwined under Zubik v. Burwell back to their courts of appeals for decisions. The language that the Court used is crucial, however, as they stated that whichever decisions the appeals courts come to, women must still be able to receive contraceptive coverage seamlessly with the rest of their health coverage.

SOURCES OF FUNDING

Public expenditures on family planning client services, FY 2010



Source: Guttmacher Institute, "Publicly Funded Family Planning Services in the United States" accessed 9 March 2016 at http://www.guttmacher.org/pubs/fb_contraceptive_serv.html

Despite efforts by the Trump Administration, the ACA has not been repealed or replaced in its entirety. However, in 2017, the ACA's contraceptive coverage guarantee (also known as the "birth control mandate") was undermined by the issuance of a Trump Administration ruling letting insurers and employers refuse to provide birth control if doing so went against their "religious beliefs" or "moral convictions." This follows in the same rhetoric of "religious freedom" exemptions that Vice President Mike Pence and Supreme Court Justice Neil Gorsuch advanced at the state level. Contrarily, on the state level, twenty-eight states have a contraceptive coverage guarantee, and Vermont, California, Illinois, and Maryland also stipulate that this coverage have no cost sharing.

Transgender men also face significant obstacles accessing contraceptives. Marginalization and discrimination make trans men who have sex with men at increased risk for unintended pregnancy and STIs. As many as 93% of transgender men who have sex with men report receiving insufficient information about their reproductive health, and one in three transgender people delay or avoid seeking reproductive healthcare because of fear of discrimination. The Obama Administration issued guidance in 2015 specifying that insurers cannot limit coverage for transgender people based on their gender identity or the sex assigned to them at birth.

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TITLE X FUNDING: ACCESS TO FAMILY PLANNING

Title X is a federal public health program that provides a critical safety net for millions of low-income Americans – about 70% of whom have income at or below the federal poverty line, and the majority of whom are women. It is the only federal grant program dedicated solely to the provision of comprehensive family planning services and provides funding to thousands of public health and family planning clinics around the country.

These clinics not only provide family planning, but they also provide a range of preventive services, including breast cancer screenings, pelvic exams, STI and HIV testing, and education.

Despite the importance of these clinics, however, anti-women's health politicians have attempted to slash, or completely eliminate, Title X funding, threatening to cut off low-income women's access to basic healthcare. Between 2010 and 2015, Congress cut funding for Title X by $30.5 million – a 10% reduction. In FY 2016, the House appropriations bill would have zeroed out Title X funding altogether. The Senate version would provide $286.5 million, the same level as fiscal year 2015, but below FY 2010 levels. Despite resquests from the Familiy Planning Coalition of more than $327 million in funding, the Trump Administration requested $286.5 million.

Funding cuts have led to a decrease in service. The number of Title X patients receiving care has shrunk by over 1 million, and there is no evidence that these patients are seeking care elsewhere.

THREE THREATS TO THE TITLE X FAMILY PLANNING PROGRAMS

The Trump administration said it would prioritize grant applications to the Title X family-planning program that come from organizations with a religious background and counsel abstinence or "natural" methods. This creates a stigma and barriers to access birth control and sexual education on birth control.

PROMOTING NATURAL FAMILY PLANNING OVER ALL OTHER CONTRACEPTIVE OPTIONS

Supporters of the abstinence-only approach repeatedly emphasize the need to offer fertility awareness methods (FAMs)—implying that currently, such methods are not sufficiently available to Title X clients. In fact, FAMs have always been part of the broad range of contraceptive methods supported by the program, and are explicitly mentioned in the Title X statute and regulations. Although opponents to reproductive freedom emphasize FAMs, they do not acknowledge the importance of ensuring women have a true choice of contraceptive methods. Nor do they mention the standard of client-centered, comprehensive contraceptive care as detailed in the Quality Family Planning Guidelines—a sharp departure from last year's funding announcement, which emphasized these guidelines throughout.

ABSTINENCE-ONLY MESSAGES

Opponents to birth control urge providers to communicate abstinence-only-until-marriage messages to adolescents. They promote this messaging using language such as "avoiding sexual risk" and "returning to a sexually risk-free status." This language is now common among abstinence-only proponents, as part of an attempt to rebrand their agenda. Abstinence-only approaches withhold information on sexual health. Research has shown that adolescents receiving these messages were less likely to use contraception or condoms when they did have sex for the first time, compared with adolescents not in these programs or who received more complete sexual health education. These approaches also perpetuate harmful stigma around sex, sexual health and sexuality, among other harms.

BIRTH CONTROL ACCESS FOR IMMIGRANT WOMEN

Laws limit immigrants' access to health insurance

Health insurance coverage plays a key role in increasing access to health care services, especially for women. Yet, in 2015, almost 18 percent of all immigrants were uninsured. In contrast, 8 percent of U.S.-born individuals were uninsured. This rate was even higher for women of reproductive age (18-54), of which 27 percent of noncitizen immigrants were uninsured, compared with 10 percent of U.S.-born women. Immigrants are more likely than U.S-born citizens to work in low-wage jobs that do not offer employer-sponsored health insurance. But that only accounts for part of the disparity: several policies limit access to federal health insurance programs for immigrants, even those lawfully present.

- Immigrants face harsh restrictions on public health coverage. Lawfully present immigrants are barred from participating in Medicaid and the Children's Health Insurance Program (CHIP) during the first five years they have lawful status. Undocumented

immigrants and young immigrants allowed to remain legally in the United States under the Deferred Action for Childhood Arrivals (DACA) program are completely banned from Medicaid and CHIP. Beyond a narrow exception, undocumented immigrants can only receive health insurance assistance if their state uses state-only funded programs to increase insurance access for undocumented immigrants. Unfortunately, only 10 states and D.C. offer any kind of health benefits to undocumented immigrants through state-funded programs.

- Undocumented immigrants and individuals with DACA status were specifically left out of the Affordable Care Act. The Affordable Care Act (ACA) prohibits undocumented immigrants from purchasing private coverage in the marketplaces – even if they pay the full cost without help from the government. Young immigrants allowed to legally remain under the DACA program are also ineligible to purchase private coverage in the health insurance marketplaces, with or without federal subsidies – while most lawfully present immigrants are eligible to purchase private insurance and receive subsidies to make private health insurance coverage affordable.

WHO IS AFFECTED BY FUNDING CUTS?

More than 4.1 million low-income women and men receive healthcare from Title X clinics. Title X patients are disproportionately Black, Hispanic, or Latino, and the majority of Title X patients in 2017 were uninsured. Around 60% of women who use a Title X clinic consider it to be their regular source of healthcare.

Cutting or eliminating funding for Title X would mean the closing of clinics across the country. Around 3,000 healthcare professionals, including nurse practitioners, physicians, nurse-midwives, physician assistants, counselors, and health educators, receive Title X funding to provide critically-needed family planning and preventive services to underserved populations.

MYTHS ABOUT TITLE X FUNDING

Legislators and anti-family planning groups in favor of defunding Title X have attempted to mislead the public about the program in order to gain support. Such myths include the argument that defunding Title X would reduce the federal deficit, when in reality federal programs that promote family planning actually reduce government spending. For every $1 spent on publicly funded family planning programs, the government saves $7 in Medicaid costs.

Another myth is that Title X funds abortion services. This is completely false. In fact, publicly funded family planning services provided through Title X, alone, helped to prevent 1 million unintended pregnancies in 2013, which would have resulted in over 500,000 unintended births and around 345,000 abortions. Around 2 million unintended pregnancies were prevented by all publicly funded family planning services.

The truth is that Title X, under current funding levels, is not meeting the needs of low-income women. Congress should increase Title X funding, not cut or eliminate it.

OTHER PUBLIC FUNDS FOR FAMILY PLANNING

Several other public programs fund family planning services for low-income women and girls, providing more than $2 billion for such services in 2010. The vast majority of this money (75%) is distributed via Medicaid programs at both the federal and state levels. Title X, however, is the only federal grant program devoted just to family planning, and helps serve individuals who do not meet the eligibility requirements for Medicaid in their states. Title X also provides significant funding for a national network of family planning centers that provide basic health care to low-income people.

FAMILY PLANNING SERVICES ARE VITAL

Comprehensive family planning services like those funded by Title X are based on science and are medically necessary. The federal government has wasted over $1.5 billion dollars since 1996 on abstinence-only education programs, which are ineffective at preventing unplanned pregnancy and the spread of STIs. Just last year, Congress allocated up to $10 million for abstinence-only-until-marriage programs. In his FY 2017 budget request, President Obama eliminated this funding for abstinence-only education programs. Nearly half of all pregnancies in the United States are unintended, and there are approximately 20 million new cases of STIs each year. We simply cannot afford to replace comprehensive family planning services with abstinence-only programs.

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INCREASE FEDERAL FAMILY PLANNING FUNDING

Millions of women in the United States are in need of publicly funded family planning services and supplies. Expanding Medicaid at the state level–currently 18 states are not adopting the Medicaid Expansion (as of Jan 16, 2018)–and increasing Title X funding are critical elements for meeting this need. Low-income women are five times more likely than affluent women to experience an unwanted pregnancy.

Twenty-one states adopted proactive measures to expand access to reproductive health services or to protect reproductive rights in 2017; notably, this total includes some measures related to abortion, in addition to contraception or other topics. Proactive measures were enacted in states in all regions of the country. Eleven states took steps to expand access to family planning. Nine states expanded insurance coverage of contraception. These include measures to:

- Prohibit cost sharing in Maine, Massachusetts, Nevada and Oregon;
- Require coverage for sterilization in Maine, Massachusetts, Nevada, Oregon and New York;
- Include coverage of over-the-counter methods in Massachusetts, Nevada, New York and Oregon; and
- Allow women to obtain up to a year's supply of a contraceptive method at one time in Colorado, Maine, Massachusetts, Nevada, New Jersey, New York, Oregon, Virginia and Washington.
- Hawaii, Maryland and Ohio enacted legislation allowing individuals to obtain prescription contraceptives from a pharmacy without first obtaining a prescription from a physician.
- Maryland and Nevada adopted measures guaranteeing the state will use its own funds to replace funding lost if the federal government excludes Planned Parenthood affiliates from receiving reimbursement for services billed under Medicaid and other federal programs.
- Illinois passed into law Medicaid funding for abortion in 2017 (the first state to do so in many years) and codified into law the landmark Supreme Court decision *Roe v. Wade.*

WHAT YOU CAN DO:

- Keep an eye on state-level access to birth control services and vote to elect and/or protect such services. After the 2010 election, many states cut reproductive healthcare funding sharply, including New Jersey, which eliminated funding, New Hampshire, which cut funding by 57%, and Texas, which cut its funding by 66%. Funding in New Hampshire was restored in 2013, but New Jersey's Governor Christie eliminated $7.5 million in reproductive health services by line-item veto each year since 2010, causing at least nine reproductive health clinics to close. Finally, in 2018, the newly elected Governor Phil Murphy restored funding. Similar cuts in Texas have resulted in the closure of 82 reproductive health care clinics. Iowa, Kentucky and South Carolina all moved to restrict public funding for birth control programs and providers in 2017, bringing to 15 the number of states that have taken aim at the reproductive healthcare safety net. These attacks have all occurred following the 2015 release of a series of deceptively edited videos by the so-called Center for Medical Progress in their quest to discredit Planned Parenthood.
- Raise awareness about the need for Title X and efforts to defund it with a rally or public education campaign on your campus, such as a teach-in or poster campaign.
- Talk with your Senators and Representative about the critical need for family planning funding.