

UNINTENDED PREGNANCY AND PUBLIC POLICY

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I. INTRODUCTION

Basic demographic facts rarely astonish. Here, however, is an exception that proves the rule: about half of all pregnancies in the United States are unintended.¹ The situation is even starker for some demographic subgroups. For instance, more than two-thirds of pregnancies among African-American women are unintended, as are more than 60% of pregnancies among women whose incomes place them below the federal poverty line.² A pregnancy's intendedness (or lack thereof) has wide-reaching implications. For instance, rates of single parenthood, physical abuse, and mental health problems are all higher among women who experience unintended pregnancies than among women who experience intended pregnancies. Similarly, physical and mental health problems and delinquent behavior during the teenage years are more common among children whose births were unintended than among children whose births were not. Women who experience unintended pregnancies are also relatively more likely to delay the initiation of prenatal care and are relatively less likely to breastfeed their children.³ It is, of course, difficult to parse out the extent to which these dynamics are causal rather than merely correlational. Some studies have used sophisticated analytical techniques to determine whether there is a causal relationship between unintended pregnancy and

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1. Lawrence B. Finer & Mia R. Zolna, *Unintended Pregnancy in the United States: Incidence and Disparities, 2006*, 84 *CONTRACEPTION* 478, 480 (2011).

2. *Id.* at 481.

3. Information on the marriage rates of women who experience intended and unintended pregnancies is taken from unpublished tabulations of data gathered by the Guttmacher Institute. For a survey of the literature on the association between pregnancy intentions and the other maternal and child outcomes described here, see CASSANDRA LOGAN ET AL., *THE CONSEQUENCES OF UNINTENDED CHILDBEARING: A WHITE PAPER 3* (2007), available at <http://www.thenationalcampaign.org/resources/pdf/consequences.pdf>. Cf. Theodore J. Joyce et al., *The Effect of Pregnancy Intention on Child Development*, 37 *DEMOGRAPHY* 83, 88–93 (2000).

maternal and child outcomes, and these studies' findings tend to show that the former affects the latter negatively.⁴

Unintended pregnancy has important implications not only for the women and children who are directly affected, but also for society at large. Well-designed studies have shown that reductions in unintended childbearing depress crime rates and welfare receipt.⁵ In another recent study, Emily Monea and I find that

4. For example, some studies have exploited plausibly exogenous variation over time in state laws governing access to oral contraception to estimate the effect of access to birth control on various maternal outcomes. Because access to contraception lowers the risk of experiencing an unintended pregnancy, the results of these studies can reasonably be interpreted as reflecting in part the effect of reductions in unintended pregnancy on the authors' outcomes of interest. These studies' findings suggest that expansions in access to the pill have raised women's educational attainment and increased their rates of labor force participation. 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, 289–94 (2006); Claudia Goldin & Lawrence F. Katz, *The Power of the Pill: Oral Contraceptives and Women's Career and Marriage Decisions*, 110 J. POL. ECON. 730, 730–31 (2002); Elizabeth Oltmans Ananat & Daniel M. Hungerman, *The Power of the Pill for the Marginal Child: Oral Contraception's Effects on Fertility, Abortion, and Maternal & Child Characteristics* 1–3 (Nat'l Bureau of Econ. Research, Working Paper, March 2008), available at http://nd.edu/~dhungerm/Power_of_Pill.pdf. See also Amalia R. Miller, *Motherhood Delay and the Human Capital of the Next Generation*, 99 AM. ECON. REV. 154, 156–57 (2009), in which the author instruments for mothers' age at first birth using information on biological fertility shocks such as the occurrence of miscarriages. She finds that delayed childbearing leads to higher standardized test scores for firstborn children. In addition, some scholars have exploited variation in state abortion laws over time in an attempt to identify the effect of access to legal abortion on the characteristics of a given birth cohort. Because increased access to abortion reduces the number of unintended births, these studies' results can reasonably be interpreted as reflecting in part the effect of reductions in unintended childbearing on the authors' outcomes of interest. See, for example, Elizabeth Oltmans Ananat et al., *Abortion and Selection*, 91 REV. ECON. & STAT. 124, 124 (2009), in which the authors find that previous expansions in access to legal abortion increased the probability of eventual college graduation among the children in the affected birth cohort; and see Jonathan Gruber et al., *Abortion Legalization and Child Living Circumstances: Who is the 'Marginal Child'?*, 114 Q.J. ECON. 263, 265 (1999), in which the authors find that such expansions reduced the likelihood that members of the affected birth cohort would live in poverty or die during infancy.

5. See John J. Donohue III & Steven D. Levitt, *The Impact of Legalized Abortion on Crime*, 116 Q.J. ECON. 379, 386 (2001). The authors attempt to identify the effect of access to legal abortion on the crime rate among members of a given birth cohort by exploiting variation in state abortion laws over time. They find that expansions in the availability of abortion caused the members of the affected birth cohort(s) to commit less crime on a per capita basis. Ananat et al., *supra* note 4, at 125, and Gruber et al., *supra* note 4, at 281, also find that increases in abortion access caused the members of the affected birth cohort to be less likely to claim welfare assistance.

taxpayers spend about \$11 billion each year on publicly subsidized medical care for women who experience unintended pregnancies and for infants whose conception was unintended.⁶ We conclude that, if all unintended pregnancies could be prevented, the resulting taxpayer savings on Medicaid-subsidized medical care alone would approach the amount that the federal government spends on the Head Start program each year.⁷

Perhaps because it is both so common and so consequential, unintended pregnancy has slowly seeped into our political discourse and our policy debates. Although there remains considerable disagreement as to how we should go about reducing unintended pregnancy, there is broad agreement about the importance of the underlying goal. President Obama seized on this consensus in his speech at the 2008 Democratic National Convention when he said that “[w]e may not agree on abortion, but surely we can agree on reducing the number of unwanted pregnancies.”⁸ This Essay addresses the question of how public policy can contribute to the achievement of this broadly held objective. I begin by laying out a set of basic facts about trends in unintended pregnancy and related outcomes over time, after which I review research findings on some of the most important root causes of these phenomena. I then discuss the policy and legal frameworks that have been developed to address these root causes, and I describe new evidence showing that certain well-designed, evidence-based policies are likely to effect meaningful reductions in unintended pregnancy in a cost-effective way. I conclude by assessing the recent performance of policymakers in this arena and offering some thoughts about the way forward.

II. UNINTENDED PREGNANCY: MEASUREMENT AND TRENDS

In order to proceed with a more detailed discussion of the prevalence of unintended pregnancy, we must first define the phenomenon of interest as precisely as possible. The primary source of data on pregnancy intentions is the National Survey of

6. See Emily Monea & Adam Thomas, *Unintended Pregnancy and Taxpayer Spending*, 43 PERSP. ON SEXUAL & REPROD. HEALTH 88, 88–93 (2011). See Adam Sonfield et al., *The Public Costs of Births Resulting from Unintended Pregnancies: National and State-Level Estimates*, 43 PERSP. ON SEXUAL & REPROD. HEALTH 94, 94 (2011), for a similar analysis that arrives at much the same conclusion.

7. Monea & Thomas, *supra* note 6, at 92.

8. Barack Obama, Democratic Nominee for President, Nomination Acceptance Speech at 2008 Democratic Convention Speech, in Cameron Brown et al., *Barack Obama's Speech at the Democratic National Convention*, N.Y. TIMES (Aug. 28, 2009), http://elections.nytimes.com/2008/president/conventions/videos/20080828_OBAMA_SPEECH.html.

Family Growth (“NSFG”), a cross-sectional survey that was first fielded in 1973 and has been administered to new samples every few years thereafter.⁹ The incidence of unintended pregnancy is measured using responses to questions in the NSFG that attempt to assess a woman’s pregnancy intentions before she became pregnant. The NSFG does not actually contain questions that make explicit reference to unintended pregnancy. Rather, women who report having experienced a pregnancy in the relatively recent past are asked questions designed to determine the following: (a) before the respondent became pregnant, did she wish to have a (or another) child at some point in the future?; and (b) if the answer to the first question is “yes,” would the respondent have preferred that the focal pregnancy occur later than it actually occurred? If the answer to the first question is “no,” then the respondent’s pregnancy is classified as having been “unwanted;” if the answer to the second question is “yes,” then the pregnancy is classified as having been “mistimed.” The number of unintended pregnancies is then taken to be the sum of the number of mistimed and unwanted pregnancies.¹⁰

The fact that unintended pregnancy is measured using retrospective survey data is inherently problematic. It is likely that some share of genuinely unintended pregnancies resulting in live births are later reported to have been intended, since mothers may feel reluctant to imply that their children’s conception was a mistake.¹¹ The challenges of measuring unintended pregnancy accurately are illustrated by a number of apparent contradictions in NSFG survey data. For example, only 68% of women who report having experienced a pregnancy resulting from contraceptive failure also said that the pregnancy in question was unintended.¹² Additionally, about half of pregnancies that are reported to have been unintended occurred to women

9. JAMES M. LEPOWSKI ET AL., NATIONAL CENTER FOR HEALTH STATISTICS, THE 2006–2010 NATIONAL SURVEY OF FAMILY GROWTH: SAMPLE DESIGN AND ANALYSIS OF A CONTINUOUS SURVEY 2 (2010), available at http://www.cdc.gov/nchs/data/series/sr_02/sr02_150.pdf.

10. See John Santelli et al., *The Measurement and Meaning of Unintended Pregnancy*, 35 PERSP. ON SEXUAL & REPROD. HEALTH 94, 94 (2003). The authors also note that there is a subtle distinction between *unintended* pregnancies and *unplanned* pregnancies. The latter are defined as pregnancies that occur either when a woman used contraception or when she did not use contraception but did not desire to become pregnant. *Id.* There is a great deal of overlap between the group of pregnancies that are classified as unplanned and the group of pregnancies that are classified as unintended. For ease of exposition, I focus solely on the latter.

11. *Id.* at 96.

12. *Id.* at 95.

who also reported that they were not using contraception at the time that they became pregnant.¹³ Some of these inconsistencies may reflect inaccurate retrospective reporting of one's intentions at the time that these pregnancies occurred. But it is also likely that some survey respondents simply feel ambivalent about their pregnancies. Thus, straightforward survey questions may not be adequate to measure the complex emotional and psychological dynamics underlying attitudes related to sex and pregnancy.¹⁴

On the whole, then, there is reason to maintain a measure of skepticism about the way in which information on unintended pregnancy is gathered. I would argue, however, that these data are valuable nonetheless. Survey measures clearly capture a large portion of the variation in genuine pregnancy intentions—researchers have found that women who report that they want to have more children are in fact much more likely than women who do not to experience a subsequent pregnancy¹⁵—and, perhaps just as importantly, these data are the best available tool for the measurement of unintended pregnancy. Thus, I occasionally draw in the discussion below on survey data related to the incidence of unintended pregnancy. Wherever possible, however, I rely instead on more concrete correlates of intendedness. For example, I noted earlier that there is a correlation between single parenthood and unintended childbearing, and data presented below also show that almost all teen pregnancies are unintended. In addition, more than 90% of abortions involve pregnancies that are unintended, rather than intended.¹⁶ As such, I will sometimes focus on rates of out-of-wedlock childbearing, teen pregnancy, and abortion, given the considerable overlap that exists between these outcomes and unintended pregnancy. In addition, I cite evidence in a subsequent section on the number of pregnancies that would be prevented by various public policies. Implicit in my discussion of this evidence is an assumption that, if a certain number of pregnancies are prevented by a policy that (say) discourages unprotected intercourse, it must be the case that those pregnancies would have been unintended, had they occurred.

The survey data on unintended pregnancy—flawed though they may be—reveal striking subgroup differences. Figures 1–3¹⁷ show trends in survey-based measures of unintended pregnancy,

13. *Id.*

14. *Id.* at 95–97.

15. *Id.* at 96.

16. Based on unpublished tabulations of data gathered by the Guttmacher Institute (on file with author). See *supra* note 3.

17. See Figures 1–3, *infra* Appendix A.

unintended childbearing, and abortion, delineated by age. The most recent year for which all necessary data are available is 2006, and consistent series for these outcomes can be produced using information from the 1994, 2001, and 2006 cross sections of the NSFG.¹⁸ Figure 1 shows trends among all women of

18. In fact, while the NSFG provides the best available information on pregnancy intentions, the highest-quality data on birth rates are produced by the National Vital Statistics System ("NVSS"), and the highest-quality data on abortion rates are produced by the Guttmacher Institute. Because NVSS data are publicly available and Guttmacher data are not, the Guttmacher Institute has become the primary source of information on the incidence of unintended pregnancy. Guttmacher reports combine NSFG estimates of the share of pregnancies that are unintended with NVSS birth counts and their own estimates of the incidence of abortion and fetal loss in order to produce estimates of the rate of unintended pregnancy. Guttmacher does not report estimates for each of these outcomes in every year. The years encompassed in Figures 1–3 are the most recent years for which data are available on all relevant outcomes. Guttmacher publications tend to report estimates for multiple years in order to show trends over time. For example, *Finer and Zolna* report estimated rates of unintended pregnancy, unintended childbearing, and abortion for 2006 and 2001. See *Finer & Zolna, supra* note 1, at 481, 483. *Finer and Henshaw* report estimates for 2001 and 1994 in their study. See Lawrence B. *Finer & Stanley K. Henshaw, Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 PERSP. ON SEXUAL & REPROD. HEALTH 90, 93 (2006). Finally, *Henshaw* reports estimates for 1994, 1987, and 1981. See *Stanley K. Henshaw, Unintended Pregnancy in the United States*, 30 FAM. PLAN. PERSP. 24, 27 (1998). There are modest differences between reports in terms of their estimates of particular outcomes for the same year. For instance, *Finer and Zolna* report that the unintended pregnancy rate for 2001 was 50 per 1,000 women, *supra* note 1, at 481, but *Finer and Henshaw's* estimate for the same outcome in the same year was 51 per 1,000 women. See *Finer & Henshaw, supra* note 18, at 93. Guttmacher staff informed me that differences of this sort are a function of small changes that they have instituted over time in the measurement of these outcomes, and they have told me that my choice of year for the purposes of this analysis is reasonably trivial. As such, I chose to use the most recently available data for all estimates. Guttmacher publications generally report outcomes separately for women in their early and late twenties, and they report both counts and rates for many outcomes. I used these data and other information contained in the reports referenced in this footnote to combine tallies of the number of pregnancies, births, and abortions for women in these two age categories in order to create a single set of estimates for all women in their twenties. The estimates reported in Figures 1–3 were constructed using information taken from the multiple sources. Age-specific data on rates of unintended pregnancy and unintended childbearing, on the percent of pregnancies that are unintended, and on the percent of pregnancies resulting in abortion for 2001 and 2006 were taken from *Finer & Zolna, supra* note 1, at 481, 483; age-specific data on rates of unintended pregnancy and unintended childbearing, on the percent of pregnancies that are unintended, and on the percent of pregnancies resulting in abortion for 1994 were taken from *Finer & Henshaw, supra* note 18, at 93; age-specific data on the number of unintended pregnancies in 2006 were taken from *Finer & Zolna, supra* note 1, at 481; age-specific data on the number of unintended pregnancies in 2001 were taken from *Finer & Henshaw, supra*

childbearing age. This figure gives the impression that not much has happened over the past several years. Both the unintended pregnancy rate (i.e., the annual number of unintended pregnancies per 1,000 women) and the percent of pregnancies that are unintended remained fairly stable over the period of time covered by the graph. There was a modest decline in the abortion rate over this period, but that decrease was offset by a modest increase in the unintended birth rate. The net effect of these two trends was relative stability in the overall number of unintended *pregnancies*.

These aggregate trends conceal a more interesting story at the subgroup level. Figure 2 shows trends in rates of unintended pregnancy, unintended childbearing, and abortion among teens; and Figure 3 shows trends in similar outcomes among young adults between the ages of twenty and twenty-nine. Because the overall rate of pregnancy is often an outcome of independent interest for teens, Figure 2 also shows trends in the overall teen pregnancy rate. I do not report abortion rate estimates for women in their twenties because the available data do not allow me to produce a consistent series for this group over the period covered by the graph. For these women, I present instead a set of estimates for a related outcome: the share of unintended pregnancies that result in abortion. I do not report trends for women over the age of thirty, in part to conserve space and in part because most pregnancies—nearly two-thirds—are to women who fall below this age threshold. Trends in unintended pregnancy, unintended childbearing, and abortion among older women are reasonably similar to the trends shown here for women in their twenties.¹⁹

note 18, at 93; age-specific data on the number of unintended pregnancies in 1994 were taken from Henshaw, *supra* note 18, at 26; data on abortion rates for women aged 15–44 for all three years were taken from Rachel K. Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43 PERSP. ON SEXUAL & REPROD. HEALTH 41, 43 (2011); data on teen abortion rates for all three years were taken from Kathryn Kost et al., *U.S. Teenage Pregnancies, Births, and Abortions: National and State Trends by Race and Ethnicity* 6 (Guttmacher Institute, Working Paper, January 2010), available at <http://www.guttmacher.org/pubs/USTPtrends.pdf>; data on teen pregnancy rates (without regard to pregnancy intention) in 2006 and 2001 were taken from Finer & Zolna, *supra* note 1, at 481; and data on teen pregnancy rates in 1994 (again, without regard to pregnancy intention) were taken from Finer & Henshaw, *supra* note 18, at 93.

19. However, the *levels* of the quantities estimated for Figures 1–3, *infra*, Appendix A, are quite a bit lower among women in their thirties. For example, the data that I used to construct the series shown in Figures 1–3 indicate that the unintended birth rate among women in their twenties increased by about 15% between 1994 and 2001 and then by another 15% or so between 2001 and

Focusing first on Figure 2, a comparison of the rates of *overall* pregnancy and *unintended* pregnancy among teens in any given year indicates that (not surprisingly) the substantial majority of teen pregnancies are unintended. The most important insight from this graph, however, is that there has clearly been a reduction since the mid-1990s in overall pregnancy rates—and therefore in unintended pregnancy rates—among teens. Rates of unintended childbearing and abortion have also been in decline among teenage girls. These declines have been sizeable. Over the twelve years covered by the graph, rates of teen pregnancy and unintended pregnancy among teens dropped by around 30%. These reductions were attributable to a reasonably large (about 15%) reduction in unintended childbearing and an even more substantial (more than 40%) reduction in the number of abortions. Figure 3 shows that the story is quite different for older women: rates of unintended childbearing have *increased* among women in their twenties, although this increase has been offset somewhat by a decline in abortion. The net result of these two trends has been a modest increase in rates of unintended pregnancy among women in this age group.

To summarize, then, the “lack of news” suggested by the relative stability in the aggregate rate of unintended pregnancy belies two important facts. First, the incidence of abortion has declined in recent years for both teens and young adults.²⁰ And

2006. Comparable estimates taken from the same data sources indicate that unintended childbearing increased by about a third between 1994 and 2001 and by about 10% between 2001 and 2006 among women in their early thirties. For both groups, then, there has been a notable increase in rates of unintended childbearing between 1994 and 2006. However, the levels of those rates differ between the two groups. For instance, in 2006, the unintended birth rate per 1,000 women was (as is shown in Figure 3) about 45 for women in their twenties. The comparable rate in the same year was only about 22 per 1,000 women in their early thirties. The fact that older women have lower unintended pregnancy and unintended birth rates than women in their teens and twenties explains why the overall rates shown in Figure 1—which presents estimates for all women under the age of 45—are lower than the rates for teenage girls or for young adults as reported in Figures 2 and 3.

20. In fact, Figure 3, *infra*, Appendix A, does not report the incidence of abortion for women in their twenties. Due to data limitations, the figure reports instead the percent of unintended pregnancies that result in an abortion. By taking the product of this quantity and the unintended pregnancy rate in a given year, I can calculate the number of unintended pregnancies that result in abortion per 1,000 women aged 20–29. (Unfortunately, I cannot use this approach to calculate an overall abortion rate, since: (1) a small number of abortions are the result of intended pregnancies, and (2) there are no publicly available data on the share of intended pregnancies that result in abortion.) According to my calculations, the “unintended abortion rate” among women in their twenties dropped from 46.8% in 1994 to 38.3% in 2006, which represents

second, the indicators shown in Figures 1–3 suggest that considerable progress has been made in lowering rates of unintended childbearing among teens but not among their older counterparts. It is also worth noting that the most recent data show that, after declining for a decade and a half, the teen birth rate increased slightly in 2006 and 2007, then decreased in 2008 and 2009, and now sits at the lowest level ever recorded.²¹ Although it is difficult to determine what these data points portend for the future, we can conclude that the recent trend among teens has been a bumpy but generally promising one. The most pressing question is this: what can be done to reinforce the progress that has been made among teens and to reverse the more discouraging trends among women in their twenties? The next section begins to answer this question by exploring the underlying causes of unintended pregnancy and childbearing.

III. WHAT ARE THE CAUSES OF UNINTENDED PREGNANCY?

In a recent article, my co-authors and I argue that unintended pregnancies occur for three reasons: a lack of motivation to avoid unprotected sex; insufficient knowledge about how best to avoid unintended pregnancy; and limited access to effective contraception.²² There is evidence to suggest that each of these three explanations is important. With respect to the first explanation, a number of societal factors and personal circumstances can affect an individual's motivation to avoid risky sexual behavior. For instance, sociologists have produced a rich body of research showing that many young women in low-income neighborhoods believe that their economic prospects are quite limited and therefore assume that they will face few detrimental long-run consequences if they have children either as teenagers or out of wedlock. In their landmark work on this topic, Edin and Kefalas quote a single mother in her mid-twenties who says, "I could sit here and say, 'Oh, I would have . . . gone to a four year college' [if I hadn't gotten pregnant, but] I probably wouldn't have."²³ Based on their extensive ethnographic research, the authors con-

a reduction of about 18% in the number of abortions resulting from unintended pregnancies.

21. BRADY E. HAMILTON ET AL., NAT'L VITAL STATISTICS SYSTEM, BIRTHS: PRELIMINARY DATA FOR 2010 1 (2011), available at http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_02.pdf.

22. Isabel Sawhill, Adam Thomas & Emily Monea, *An Ounce of Prevention: Policy Prescriptions for Reducing the Prevalence of Fragile Families*, 20 FUTURE CHILD 133, 133 (2010).

23. KATHRYN EDIN & MARIA KEFALAS, PROMISES I CAN KEEP: WHY POOR WOMEN PUT MOTHERHOOD BEFORE MARRIAGE 171 (2005).

clude that the limited perceived costs of single motherhood among low-income women leads to a deep-seated ambivalence about whether or not they truly want to avoid becoming pregnant. In assessing the attitudes of single mothers in their study, the authors write that “typically, young women describe their pregnancies as ‘not exactly planned’ yet ‘not exactly avoided’ either—as only a few were using any form of contraception at all when their ‘unplanned’ child was conceived.”²⁴

The thrust of Edin and Kefalas’s conclusions is reinforced by the results of Kearney and Levine’s 2011 study. The authors assume that the level of income inequality is an important determinant of low-income individuals’ perceptions of their economic prospects, and they find that disadvantaged teen females are relatively more likely to experience non-marital births if they live in locations characterized by relatively higher levels of income inequality.²⁵ It is important to bear in mind, however, that ambivalence toward unintended pregnancy and out-of-wedlock childbearing is not limited to disadvantaged groups. A nationally representative survey of unmarried young men and women conducted by the National Campaign to Prevent Teen and Unplanned Pregnancy shows that 38% of males and 44% of females agree with the statement that “[i]t doesn’t matter whether you use birth control or not; when it is your time to get pregnant it will happen.”²⁶ These attitudes are consistent with broad cultural trends: over time, respondents to national surveys have become increasingly unlikely to express disapproval of cohabitation or premarital sex or to agree with contentions that unmarried childbearing is immoral or destructive to society.²⁷ On the whole, then, cultural and economic circumstances have conspired to create a sense of ambivalence and fatalism among many young adults that ultimately diminishes their motivation to curb the kinds of behaviors that cause unintended pregnancies to occur.

24. *Id.* at 37.

25. See Melissa Schettini Kearney & Phillip B. Levine, *Income Inequality and Early Non-Marital Childbearing: An Economic Exploration of the “Culture of Despair,”* 4, 29 (Nat’l Bureau of Econ. Research, Working Paper No. 17157, 2011), <http://www.nber.org/papers/w17157.pdf>.

26. KELLEEN KAYE ET AL., NAT’L CAMPAIGN TO PREVENT TEEN AND UNPLANNED PREGNANCY, THE FOG ZONE: HOW MISPERCEPTIONS, MAGICAL THINKING, AND AMBIVALENCE PUT YOUNG ADULTS AT RISK FOR UNPLANNED PREGNANCY 6 (2009).

27. See PEW RESEARCH CENTER, GENERATION GAP IN VALUES, BEHAVIORS: AS MARRIAGE AND PARENTHOOD DRIFT APART, PUBLIC IS CONCERNED ABOUT SOCIAL IMPACT 40 (2007); Arland Thornton & Linda Young-DeMarco, *Four Decades of Trends in Attitudes Toward Family Issues in the United States: The 1960s Through the 1990s*, 63 J. MARRIAGE & FAM. 1009, 1023, 1025 (2001).

There is also a wealth of evidence demonstrating the importance of the second factor referenced above: insufficient knowledge about how best to avoid an unintended pregnancy. For example, among the unmarried young adults responding to the National Campaign survey described above, almost a third reported knowing little or nothing about condoms; nearly two-thirds reported knowing little or nothing about birth control pills; and more than half reported that they have never heard of the birth control implant.²⁸ Almost 60% of young unmarried women participating in the study also said it was likely that they were infertile despite the fact that less than 10% of women in their age group actually experience fertility problems.²⁹ In addition, most female respondents reported beliefs that were at odds with clinical evidence about the health risks (or lack thereof) associated with various forms of hormonal contraception.³⁰ And perhaps most disturbingly, 90% of respondents claimed that they have all the knowledge needed to avoid an unintended pregnancy.³¹

Regarding the third factor referenced above—insufficient access to effective contraception—the evidence is somewhat mixed. It is clearly the case that, for many individuals, some of the most effective contraceptive methods would be prohibitively expensive without insurance coverage.³² For example, the total cost of a contraceptive implant approaches \$1,000.³³ Although the implant lasts for about three years on average, the bulk of these expenses are incurred up front. In addition, oral contraception, contraceptive patches, and contraceptive rings can each cost more than \$500 per year if they are not covered by health insurance.³⁴ Condoms, on the other hand, are reasonably inexpensive—they cost about \$1.00 each—and although they are much more susceptible to user error and are therefore less effective than the other methods mentioned here, they nonetheless reduce the risk of pregnancy dramatically if used properly.³⁵

28. KAYE ET AL., *supra* note 26, at 8.

29. *Id.* at 9.

30. *Id.*

31. *Id.* at 10.

32. All cost estimates cited in this paragraph are based on the author's analysis of data taken from James Trussell et al., *Cost Effectiveness of Contraceptives in the United States*, 79 *CONTRACEPTION* 5, 10 (2009). These cost figures account for expenses associated with the contraception itself and with related medical services.

33. *Id.*

34. *Id.*

35. *Id.*

Speaking broadly, then, there is somewhat of a positive correlation between a method's effectiveness and its cost.

Although it seems plausible that the comparatively higher cost of the most effective methods might create a barrier to their use, survey respondents tend not to cite cost concerns when explaining why they do not use more effective contraceptive methods.³⁶ At the same time, evidence cited later in this Essay suggests that, when the cost of contraception is publicly subsidized, the frequency of contraceptive use increases and rates of unintended pregnancy and childbearing are reduced as a result.³⁷ These findings provide the most convincing evidence that the cost of effective contraception places upward pressure on the rate of unintended pregnancy.

IV. WHAT CAN BE DONE TO REDUCE THE RATE OF UNINTENDED PREGNANCY?

There are already public policies in place that attack each of the causes of unintended pregnancy laid out in the previous section. There are, for instance, several policies that have the potential to affect the first of these three root causes: a lack of motivation to avoid unintended pregnancy. As an example, several local media campaigns encouraging safer sexual behavior have been implemented in recent years. Most of these campaigns tout the benefits of condom use as a way of reducing the spread of sexually transmitted infections, and some of them have been evaluated by researchers who compare changes in condom use in cities where campaigns were implemented to changes in similar cities where campaigns were not implemented.³⁸ Differences between the trends in condom use in comparable "treatment" and "control" municipalities are assumed to reflect the effects of these media campaigns. In a widely cited paper, Leslie Snyder and her coauthors combine the results of these evaluations and conclude that, as a group, they changed the behavior of about 6% of the members of their target populations.³⁹

36. See JENNIFER J. FROST ET AL., GUTTMACHER INST., IN BRIEF: IMPROVING CONTRACEPTIVE USE IN THE UNITED STATES 3–4 (2008); NAT'L CAMPAIGN TO PREVENT TEEN AND UNPLANNED PREGNANCY, MAGICAL THINKING: YOUNG ADULTS' ATTITUDES AND BELIEFS ABOUT SEX, CONTRACEPTION, AND UNPLANNED PREGNANCY 7 (2008).

37. See *infra* notes 57–60 and accompanying text.

38. See Adam Thomas, *Three Strategies to Prevent Unintended Pregnancy*, 32 J. POL'Y ANALYSIS & MGMT. 1, 8 (2012).

39. Leslie B. Snyder et al., *A Meta-Analysis of the Effect of Mediated Health Communication Campaigns on Behavior Change in the United States*, 9 J. HEALTH COMM. 71, 86 (2004).

Although this might sound like a “small” effect, evidence presented below shows that an impact of this magnitude is sufficient to produce returns to taxpayers that exceed the costs of these campaigns.

Another policy with the potential to affect motivation is child support enforcement, since stricter enforcement provides an incentive to avoid non-marital childbearing by raising its cost. The federal government and many state governments have enacted laws over the years that improve their ability to locate absent fathers, obtain child support orders, and secure payments from them. One well-designed study analyzes changes in child support enforcement and out-of-wedlock childbearing within states over time.⁴⁰ The study concludes that increases in child support enforcement during the 1980s and 1990s resulted in a reduction of about 12% in out-of-wedlock births.⁴¹

Child support enforcement measures and policies that promote economic mobility might be thought of as opposite sides of the same coin: whereas the former discourage unprotected sex by raising the cost of out-of-wedlock childbearing, the latter create the same incentives by raising the payoff to playing by the rules. In other words, low-income individuals like the ones included in Edin and Kefalas’s study may change their behavior if they can be convinced that the avoidance of non-marital childbearing will genuinely brighten their economic prospects. A handful of analyses have tested this hypothesis in various ways.

40. Irwin Garfinkel et al., *The Roles of Child Support Enforcement and Welfare in Non-Marital Childbearing*, 16 J. POPULATION ECON. 55, 61–66 (2003).

41. *Id.* at 67–68. A variety of changes have also been made to welfare programs that, like increases in child support enforcement, should improve incentives to avoid unprotected sex by raising the cost of single parenthood. These changes include a reduction in the real (inflation-adjusted) value of cash assistance benefits, a requirement that mothers under the age of eighteen live with a parent or guardian and enroll in school as a condition of receiving cash assistance, and a requirement that adult recipients work or look for employment. See Sawhill, Thomas & Monea, *supra* note 22, at 141–42. One well-designed synthesis of the best available evidence found that these policy changes had little if any effect on teen birth rates. See LISA A. GENNETIAN ET AL., HOW WELFARE AND WORK POLICIES FOR PARENTS AFFECT ADOLESCENTS: A SYNTHESIS OF RESEARCH 21 (2002); cf. Leonard M. Lopoo & Thomas DeLeire, *Did Welfare Reform Influence the Fertility of Young Teens?*, 25 J. POL’Y ANALYSIS & MGMT. 275, 291 (2006). Garfinkel et al., *supra*, note 40, at 67–68, find suggestive evidence that these policies may have had a modest effect on non-marital childbearing, but they also find that child support enforcement had a larger and more robust effect. My assessment of this literature is that the evidence regarding the effect of changes in welfare policy on out-of-wedlock childbearing is mixed at best, while the evidence on the effect of child support enforcement is more convincing.

For example, one study finds that teens who live in states with relatively lower college tuition costs are relatively less likely to engage in risky sexual behavior during their high school years.⁴² A related study posits that teenage girls determine the “income penalty” associated with teenage childbearing by comparing the economic well-being of demographically similar women who are somewhat older than they and who had children as teenagers with the well-being of demographically similar women who are of the same age who did not have teen births.⁴³ The authors find that larger perceived income losses associated with teen childbearing were correlated with lower birth rates among the girls in their sample.

On the whole, then, the research literature suggests that strategies such as media campaigns whose explicit goal is to affect individuals’ motivations and indirect strategies that change the incentives associated with out-of-wedlock childbearing both have the potential to reduce the number of out-of-wedlock births and, by extension, the number of unintended pregnancies. One can also make a compelling evidence-based case for programs that improve individuals’ knowledge about how to protect themselves from unintended pregnancy. Most of the programs falling under this umbrella are geared towards teens in particular. These programs—which are typically referred to as “sex education programs” or “teen pregnancy prevention programs”—are designed to provide participants with information about the risks of unprotected sex and about how to avoid becoming pregnant. Some of these programs encourage sexual abstinence. Others stress the fact that abstinence is the only sure-fire way of avoiding pregnancy but also provide information on contraceptive use for participants who might choose to become or remain sexually active.

These programs are occasionally confronted with legal challenges. For example, in *Brown v. Hot, Sexy and Safer Productions*, a group of public high school students and their parents brought action against both the high school and the developer of a sexual education program that was implemented in that school.⁴⁴ These students and their parents objected to what they considered to be the excessively lewd and graphic content of the program. The U.S. Court of Appeals for the First Circuit, however, ruled in 1995 that the plaintiffs had “failed to demonstrate an

42. See Benjamin W. Cowan, *Forward-Thinking Teens: The Effects of College Costs on Adolescent Risky Behavior*, 30 *ECON. EDUC. REV.* 813, 823 (2011).

43. See Barbara Wolfe et al., *Do Youth Nonmarital Childbearing Choices Reflect Income and Relationship Expectations?*, 20 *J. POPULATION ECON.* 73, 86–87 (2007).

44. 68 F.3d 525 (1st Cir. 1995).

intrusion of constitutional magnitude” on parents’ rights to direct the upbringing of their children.⁴⁵ More recently, in *Leebaert v. Harrington*, the parent of a public school student objected to the inclusion of a sexual health module in the school’s health and hygiene curriculum even though the school allowed the student to opt out of the module.⁴⁶ The parent claimed that the entire health and hygiene program represented a violation of his constitutionally protected rights to religious freedom and family privacy. The U.S. Court of Appeals for the Second Circuit ruled in favor of the school system in 2003, noting that the student was given the right to opt out of the module and concluding that the parent did not have a basic right to excuse his son from the overall program.⁴⁷ Indeed, in her review of case law involving challenges to the validity or constitutionality of sexual education programs, Varley concludes that courts usually find in favor of the defendant school system by ruling that schools’ authority to determine the content of their curricula supersedes families’ rights to privacy and parental control.⁴⁸

There is considerable variation in terms of the effectiveness of sexual education programs. High-quality studies tend to show that “abstinence-only” programs do not have much of an effect

45. *Id.* at 533; see, e.g., *Religious Liberty: Hearing on Before the S. Comm. on the Judiciary*, 106th Cong. 7–14 (1999) (statement of Steven T. McFarland, Christian Legal Society); Alyssa Varley, *Sexuality in Education*, 6 GEO. J. GENDER & L. 533, 543 (2005).

46. 332 F.3d 134 (2d Cir. 2003).

47. *Id.* at 142–43.

48. Varley, *supra* note 45, at 544. A possible exception to this rule pertains to programs that promote an explicitly religious point of view. In *ACLU of Massachusetts v. Sebelius*, 697 F. Supp. 2d 200 (D. Mass. 2010), the Massachusetts chapter of the American Civil Liberties Union brought suit in 2003 against the department of Health and Human Services (HHS) over its funding of an abstinence program called the “Silver Ring Thing.” See Complaint, *ACLU of Massachusetts v. Sebelius*, 697 F. Supp. 2d 200 (D. Mass. 2010); see also Ceci Connolly, *Federal Funds for Abstinence Group Withheld*, WASH. POST, Aug. 23, 2005, at A5. The lawsuit contended that the federally subsidized program’s curriculum was “permeated with religion.” For example, each graduate of the program signed a pledge “before God almighty” to remain abstinent and received a silver ring inscribed with a bible passage. *Id.* Three months after the ACLU brought suit, HHS ordered the group that developed the program to submit a “corrective action plan” in order to secure future funding. *Id.* As part of a settlement with the ACLU several months later, the federal government then stopped its financing of the group altogether. See Katie Zezima, *Massachusetts: Money for Group is Cut*, N.Y. TIMES, Feb. 25, 2006, at A9. Although it is impossible to know with certainty how the court would have ruled on this matter, the fact that the Bush administration settled out of court suggests that they may have had concerns about the strength of the ACLU’s case.

on sexual behavior.⁴⁹ There is one important exception to this general rule: a recent high-quality study has shown that a local intervention implemented in an urban setting in the northeastern United States did in fact have a substantial impact on the probability of having sex for the first time.⁵⁰ However, this intervention was implemented for girls aged twelve to thirteen. A fair reading of the research literature thus suggests that, although we have a bit of evidence that abstinence-only programs may in fact have an effect on the sexual behavior of pre-teens and young teens, there is little convincing evidence to suggest that these programs have a similar impact among older teens.⁵¹ There is, however, reliable evidence demonstrating the efficacy of some “comprehensive” programs—i.e., programs that stress the benefits of abstinence but also teach proper contraceptive use. Several of these programs have been carefully evaluated, and a subset of these evaluated programs have been found to have had an effect on sexual frequency and/or contraceptive use. Later in this Essay, I review new evidence from a series of policy simulations showing that a well-designed national teen pregnancy prevention program could have meaningful impacts on rates of teenage pregnancy and childbearing.⁵² I developed assumptions for this simulation by synthesizing the results from evaluations of several of the most successful comprehensive teen pregnancy

49. In this case, the highest-quality studies have been conducted using random assignment. In other words, there are a number of studies in which children at a particular school or in a particular neighborhood were randomly assigned either to a “treatment group” (i.e., a group of students who were invited to participate in the program in question) or to a “control group” (i.e., students who were not invited to participate in the program). Because the treatment and control groups in these studies should be comparable save for the fact that one received the “treatment” and one did not, it is likely that any differences between them in terms of, say, birth rates are attributable to the effects of the program being evaluated. See CHRISTOPHER TRENHOLM ET AL., *IMPACTS OF FOUR TITLE V, SECTION 510 ABSTINENCE EDUCATION PROGRAMS* (2007), for an overview of the estimated effects of several different abstinence-only programs that were evaluated using random assignment research designs.

50. The program in question was evaluated using random assignment. See John B. Jemmott III et al., *Reductions in HIV Risk-Associated Sexual Behaviors Among Black Male Adolescents: Effects of an AIDS Prevention Intervention*, 82 AM. J. PUB. HEALTH 372, 374–76 (1992), for a summary of the results of this evaluation.

51. It should also be noted that this program did not advocate abstinence until marriage, which is the definition of abstinence-only sexual education laid out in federal funding guidelines. Nor did the program adopt a moralistic tone or cast sex in a negative light. For these reasons, the program described here is dissimilar to the types of programs that receive federal abstinence-only funding. *Id.* at 373–74.

52. See *infra* Part V.

prevention programs. Based on this synthesis, I conclude that one might expect a national evidence-based program that draws on the best practices of proven interventions to increase the number of teen contraceptive users by 12–13% and to increase the number of sexually inactive teens by 7–8%.⁵³

Other policies address the third root cause of unintended pregnancy: limited access to effective contraception. Since the 1970s, family planning services have been provided via state Medicaid programs and Title X of the Public Health Service Act. The former are jointly funded by state and federal dollars, and the latter is funded entirely by the federal government.⁵⁴ Thirty years ago, Title X spending substantially outpaced Medicaid family planning funding.⁵⁵ Since 1980, however, inflation-adjusted spending on Title X has declined fourfold, and Medicaid family planning spending has grown even more dramatically. In all, total inflation-adjusted government spending on family planning services increased by about 18% from 1980 to the mid-2000s. Today, more than 70% of the approximately \$1.85 billion in government spending on family planning comes from Medicaid; Title X accounts for about another 12%; and a variety of other state and federal programs make up the remainder.⁵⁶

The most compelling available evidence on the efficacy of government family planning programs can be found in a second study by Kearney and Levine. This study estimates the effects of expansions in states' Medicaid-funded family planning services that took place between the mid-1990s and the mid-2000s.⁵⁷ Eligibility for these services has historically been limited to women who are pregnant and to mothers whose incomes place them below a very low threshold. Since the mid-1990s, however, the federal government has granted waivers to about half of states

53. In developing these assumptions, I take into account the fact that the interventions incorporated into my synthesis were implemented on a small scale but that the simulated program would be implemented on a national scale. It is likely that “scaling up” these programs would dilute their effectiveness. I make the (arguably strong) assumption that scaling these programs up would cut their effectiveness in half. For further information on the way in which this synthesis was conducted, see Adam Thomas, *Estimating the Effects and Costs of Three Pregnancy-Prevention Programs 3* (Brookings Institution, Working Paper, Mar. 2011), available at http://www.brookings.edu/~media/Files/rc/papers/2011/03_pregnancy_prevention_thomas/03_pregnancy_prevention_thomas.pdf.

54. See ADAM SONFIELD ET AL., PUBLIC FUNDING FOR FAMILY PLANNING, STERILIZATION AND ABORTION SERVICES FY 1980–2006, at 5–7 (2008).

55. *Id.* at 17.

56. *Id.*

57. See Melissa S. Kearney & Phillip B. Levine, *Subsidized Contraception, Fertility, and Sexual Behavior*, 91 REV. ECON. & STAT. 137, 137 (2009).

allowing them to serve all income-eligible women—regardless of whether they are pregnant or have children—and, in most cases allowing states to raise their income-eligibility thresholds as well. Kearney and Levine compare trends in rates of contraceptive use and childbearing in states that expanded their Medicaid programs to comparable changes in states that did not implement such expansions.⁵⁸ The authors assume that the difference in these trends is attributable to the state Medicaid expansions, and they conclude that these expansions produced a reduction of about 5% in the number of sexually active adult women who fail to use contraception at a given act of intercourse.⁵⁹ They also conclude that the expansions produced reductions of about 4% in the number of births to teens and about 2% in the number of births to non-teens.⁶⁰

V. EVIDENCE-BASED POLICIES ARE COST-EFFECTIVE

In sum, there are a variety of public policies that have demonstrated potential for addressing the three root causes of unintended pregnancy. The reader may be wondering, however, whether the effects described here are “big” or “small.” Is it worth investing in policies that only reduce birth rates by 4% or that increase condom use by a mere 6%? In fact, most of us who study public policy would conclude that a 5% change in a key outcome is, in the grand scheme of things, a rather large impact. It is an unfortunate fact that policymakers rarely hit upon a “silver bullet” solution that single-handedly produces a dramatic change in rates of poverty, unemployment, unintended pregnancy, or any other needle that one might hope to move. This reality should not be all that surprising. After all, a phenomenon like unintended pregnancy is enormously complex, and it is surely affected by innumerable factors that are immune to policy manipulation. There is a limit to the amount that government can do, for example, to affect individuals’ decisions about whether to use contraception in the heat of the moment when such decisions are often made.

This consideration has two implications. First, policies should be evaluated not only in terms of their impacts on key outcomes such as (in this case) rates of unintended pregnancy and out-of-wedlock childbearing, but also in terms of whether they provide a good return on investment. We may be interested, for example, in determining whether the taxpayer savings

58. *Id.* at 143.

59. *Id.* at 148.

60. *Id.* at 137.

produced by the policies described here exceed the amount required to fund them. Policies that pay for themselves might be considered to be good investments. And second, we would probably be wise not to put all of our eggs into a single basket. In other words, policymakers should consider funding a portfolio of pregnancy prevention programs that have been shown to be cost-effective. In a newly published paper, I report results from a series of detailed policy simulations in which I model the projected effects of three evidence-based pregnancy prevention programs: a national mass media campaign encouraging condom use, a national teen pregnancy prevention program targeted on at-risk adolescents, and expansions in Medicaid family planning programs within the roughly half of states that did not implement such expansions over the last fifteen or so years.⁶¹ In the previous section, I reviewed the best available evidence on the effects of each of these programs. I incorporated that evidence into a sophisticated simulation model of family formation that was developed at the Brookings Institution. I summarize the results of these simulations here.⁶²

Each policy was simulated under a variety of different underlying assumptions. In the discussion here, I focus on the results for my preferred versions of each simulation—i.e., the versions of each simulation that rely on assumptions that I believe to be the most sensible and realistic. The results of these simulations suggest that the mass media campaign would reduce the number of unintended pregnancies by 3.6% and would reduce the number of children born into poverty by 2.2%; that the teen pregnancy program would reduce the number of teen pregnancies by 7.5% and would reduce the number of children born into poverty by 1.4%; and that the Medicaid family planning expansion would reduce the number of unintended pregnancies by 4.1% and would reduce the number of children born into poverty by 1.8%. These estimates correspond with reductions of 23,000, 15,000, and 19,000 in the number of children born into poverty under the media campaign, the teen pregnancy program, and the Medicaid expansion, respectively.

61. Thomas, *supra* note 38.

62. For a detailed discussion of the structure of the simulation model, see Adam Thomas & Emily Monea, *FamilyScape: A Simulation Model of Family Formation* (Brookings Institution, Working Paper, May 2009), available at http://www.brookings.edu/~media/Files/rc/papers/2009/05_familyscape_thomas_monea/05_familyscape_thomas_monea.pdf. For more information on the way in which the policy simulations were conducted, see Thomas, *supra* note 53; Thomas, *supra* note 38.

Are these policies cost-effective? Appendix B⁶³ shows estimated benefit-cost ratios for each policy. I calculate the policies' benefits by estimating the amount of taxpayer savings to means-tested government programs that would be generated by the reductions in unintended pregnancy produced by the simulated programs. It is important to note that my calculations allow for the possibility—indeed, the likelihood—that many pregnancies, if they are prevented today, will simply occur at a later point in time. Thus, the normative implication of these results is decidedly *not* that the births prevented by these policies ought never to occur. Rather, the point is that children, their parents, and society at large will be better off if potential parents wait to have children until they are truly prepared to assume the responsibilities of parenthood. Returning to Appendix B, I estimate that the media campaign, the teen pregnancy prevention program and the Medicaid expansion would save taxpayers \$4.31, \$2.46, and \$5.62, respectively, for each dollar that is spent on them.

It is also important to note that these estimates sometimes change when I alter the assumptions underlying the policy simulations. Most importantly, the benefit-cost ratios shown in Appendix B are calculated based on a measure of public savings that accounts for taxpayer expenditures on means-tested benefits for children up to the age of five. If instead I use a savings measure that only accounts for taxpayer savings on benefits provided to children under one year of age, only the Medicaid expansion has a benefit-cost ratio that is greater than one. However, I believe that a longer time horizon provides a more complete picture of the amount of savings that the simulated policies would actually generate. Moreover, most of the key assumptions underlying these simulations were quite conservative. Taken as a whole, these assumptions make it likely that my results *understate* the true return on investment that would be produced by the simulated policies. Even under this relatively stringent set of assumptions, my results suggest that these policies offer two important benefits. First, they would improve the lives of children and families by reducing unintended pregnancy, teen births, and child poverty. And second, they would produce savings to taxpayers that substantially exceed the amount required to fund them. In short, these policies are a win-win from the standpoint of children, their families, and society at large.

63. See *infra* page 531.

VI. THE POLITICS OF UNINTENDED PREGNANCY

Policies designed to curb unintended pregnancy are often politically controversial. Medicaid family planning funding has been a particularly prominent bone of political contention in recent years. An early version of the economic stimulus bill passed soon after President Obama's inauguration contained a provision that would have expanded Medicaid family planning subsidies, but the provision was met with fierce opposition from pro-life Republicans who argued (somewhat reasonably) that family planning policies did not belong in a bill whose focus was on creating jobs and spurring economic growth. Democrats countered (correctly) that the provision would generate public sector savings over the long run. At the President's urging, Democratic leaders stripped the family planning provision from the bill before it was debated on the House floor.⁶⁴ Of particular concern to the pro-life community is the fact that Planned Parenthood is a prominent recipient of Medicaid family planning dollars. However, the so-called Hyde amendment prohibits federal funding of abortion under most circumstances, and the approximately \$320 million that Planned Parenthood receives annually from the federal government is spent on other activities—most notably, its contraceptive services. Detractors argue that this funding allows Planned Parenthood to reallocate some of the money it would otherwise have spent on contraceptive services to abortion-related services. Thus, the argument goes, Planned Parenthood's government subsidies effectively increase the number of federally subsidized abortions even if those subsidies are not directly used to pay for abortions.⁶⁵

It is entirely possible that this argument is, on the margins, at least somewhat correct. In other words, the type of budgetary reallocation described above may sometimes occur on a small scale. What this line of argument ignores, however, is the critical fact that subsidizing contraception reduces the number of unintended pregnancies and therefore the demand for abortion. For example, I estimate that the reduction in unintended pregnancy

64. See, e.g., Adam Thomas & Isabel V. Sawhill, *Keep Politics Away from the Promise of Family Planning*, BROOKINGS INSTITUTION BLOG (Feb. 05, 2009), http://www.brookings.edu/opinions/2009/0205_family_planning_thomas_sawhill.aspx; Steven Thomma, *Obama Urges Dems to Dump Family Planning from Stimulus*, McCLATCHY NEWSPAPERS (Jan. 27, 2009), <http://www.mcclatchydc.com/2009/01/27/60820/obama-urges-dems-to-dump-family.html>.

65. See, e.g., Adam Thomas & Isabel V. Sawhill, *Family Planning Subsidies: Much Ado About Something*, BROOKINGS INSTITUTION UP FRONT BLOG (Apr. 12, 2011), http://www.brookings.edu/opinions/2011/0412_family_planning_thomas_sawhill.aspx.

produced by the simulated expansion in Medicaid family planning services described in the previous section would lead to 40,000 fewer abortions annually.⁶⁶ In order for federal family planning subsidies to produce a net increase in the number of abortions, they would therefore have to engender an enormous amount of budgetary reallocation on the part of providers such as Planned Parenthood. There is no evidence that reallocation occurs on such a scale. Thus, it is much more likely that family planning subsidies lead to a net decrease in abortion than to a net increase.⁶⁷

This consideration has not deterred some members of Congress from continuing to target family planning funding. During negotiations over the debt ceiling in the spring of 2011, congressional Republicans attempted unsuccessfully to strip Planned Parenthood of its federal funding.⁶⁸ Indeed, Senate Majority Leader Harry Reid (D-NV) stated that Republicans were holding up the entire negotiation process and risking a shutdown of the federal government over family planning funds.⁶⁹ More recently, House Republicans' initial draft of the fiscal year 2012 Labor, Health and Human Services, and Education appropriations bill proposed to cut spending for pregnancy prevention programs by 2.5% relative to last year's level of funding and by 15% relative to the president's funding request.⁷⁰ Among the most crucial aspects of these proposed cuts were reductions in spending on family planning services provided by Title X and Medicaid. The proposed legislation would also have cut millions of dollars in federal funding for evidence-based teen pregnancy prevention programs. The final version of the bill—produced after exten-

66. *Id.*

67. *Id.* See also Kearney & Levine, *supra* note 57, for a study that finds that previous expansions in Medicaid family planning subsidies reduced the incidence of abortion. This estimated effect is net of any budgetary reallocation that family planning providers might have implemented.

68. See, e.g., Jennifer Steinhauer, *No Halt to Planned Parenthood Fight*, CAUCUS: THE POLITICS AND GOVERNMENT BLOG OF THE N.Y. TIMES (Apr. 12, 2011, 6:02 PM), <http://thecaucus.blogs.nytimes.com/2011/04/12/no-halt-to-planned-parenthood-fight/>.

69. See, e.g., Jed Lewison, *Reid Says GOP Threatening Shutdown Over Family Planning, Boehner Avoids Talking Specifics*, DAILY KOS (Apr. 08, 2011, 8:32 AM), <http://www.dailykos.com/story/2011/04/08/964783/-Reid-says-GOP-threatening-shutdown-over-family-planning-funding,-Boehner-avoids-talking-specifics>.

70. Press Release, Nat'l Campaign to Prevent Teen and Unplanned Pregnancy, *House Appropriations Plan Would Severely Cut or Eliminate Funding for Programs to Prevent Teen and Unplanned Pregnancy* (Oct. 4, 2011), available at http://www.thenationalcampaign.org/policymakers/PDF/Statement_HouseAppropsBill2012.pdf.

sive negotiations between House and Senate lawmakers—restored most (but not all) of the funding that the initial draft of the House bill proposed to cut.⁷¹

The Obama administration, on the other hand, has been a vigorous proponent of evidence-based pregnancy prevention programs. For example, the health care reform legislation passed in 2010, the Patient Protection and Affordable Care Act (“ACA”), provides most states with the option of expanding eligibility for Medicaid family planning services without having to navigate the cumbersome federal waivers process. This expansion has the potential to affect states that do not have family planning waivers and a subset of waiver states that could implement further increases in their programs under the new state option. These individual states must now decide whether to take advantage of the option available to them. A separate provision in the ACA also allocates \$75 million in annual funding for evidence-based interventions to reduce teen pregnancy. These resources complement an additional \$110 million in discretionary funding for competitive grants to support both the replication of teen pregnancy prevention programs that have been shown to be effective and the implementation and evaluation of new interventions that have yet to be studied carefully.⁷² Also important is the fact that, during the summer of 2011, the administration issued a new regulation requiring health insurers to cover expenses related to contraception without cost sharing (i.e., without charging a co-pay).⁷³ Past experience suggests that this regulation—withstanding the controversy that ensued in the wake of its announcement—will likely increase contraceptive use and, as a result, reduce unintended pregnancy.

Overall, then, the Obama administration has implemented new regulations and increased funding for programs that, according to the research reviewed in this Essay, are likely to reduce abortion and child poverty, improve the lives of children and families, curb rates of unintended pregnancy and out-of-wedlock childbearing, and save taxpayers millions of dollars.

71. Press Release, Nat’l Campaign to Prevent Teen and Unplanned Pregnancy, Congress Passes FY 2012 Appropriations Bill (Dec. 20, 2011), available at <http://www.thenationalcampaign.org/policymakers/PDF/AppropriationsStatementFY12.pdf>.

72. See Adam Thomas, Ctr. on Children & Families, *Policy Solutions for Preventing Unplanned Pregnancy*, BROOKINGS 7 (2012), http://www.brookings.edu/reports/2012/03_unplanned_pregnancy_thomas.aspx.

73. See Adam Sonfield, *New Federal Protections Expand Coverage Without Cost-Sharing of Contraceptives and Other Women’s Preventive Services*, 14 GUTTMACHER POL’Y REV. 24 (Summer 2011).

Although congressional Republicans have a track record of opposing these measures, the evidence suggests reasonably definitively that the administration is on the right track.

Progress has been somewhat mixed at the state level. For example, five states have neglected to claim the State Personal Responsibility Education Program (“PREP”) grants that were made available to them by the ACA.⁷⁴ PREP grants are provided to states to subsidize implementation of teen pregnancy prevention programs that educate adolescents both on the merits of abstinence and on how to use contraception. States are required to incorporate into their PREP programs elements of other interventions that have been proven to be effective.⁷⁵ To be clear, these resources are “free” to states, which is to say that the states in question do not need to spend any of their own money to access their PREP funds. These resources have the potential to prevent thousands of teen pregnancies in the states in question. Public officials in those states would be wise to claim their share of PREP funds and use them to implement carefully structured, evidence-based programs.⁷⁶

Another potential cause for concern is the fact that a large number of states have yet to avail themselves of the new option provided by the ACA to expand their family planning services under Medicaid. Since the passage of the ACA, seven states have taken advantage of this option, and another twenty-two states have expanded access to Medicaid-subsidized contraception using waivers that were granted prior to passage of the legislation but are still in operation.⁷⁷ Thus, there are twenty-one states that have not expanded their family planning services despite the fact that they have the option to do so under the health care law.⁷⁸ In fact, a handful of states are actively seeking to *eliminate* part or

74. See *Personal Responsibility Education Program*, NAT’L CAMPAIGN TO PREVENT TEEN & UNPLANNED PREGNANCY, <http://www.thenationalcampaign.org/federal/funding/prep.aspx> (last visited Feb. 24, 2012).

75. *Id.*

76. The five states that have not yet claimed their PREP funds are Florida, Indiana, North Dakota, Texas, and Virginia, based on the author’s analysis of data reported in the United States Department of Health and Human Services, Administration for Children and Families, *FY 2011 Teen Pregnancy Prevention Grant Awards*, available at <http://www.acf.hhs.gov/programs/fysb/content/docs/11-tpp.htm#stateprep>.

77. The seven states that have availed themselves of the new state option are California, New Mexico, Ohio, Oklahoma, South Carolina, Virginia, and Wisconsin. See *State Policies in Brief: Medicaid Family Planning Eligibility Expansions*, GUTTMACHER INST. 1, 2 (2012), http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf.

78. *Id.*

all of their funding for family planning services, and some of these efforts have already succeeded. For example, the Texas legislature has cut the state's family planning budget by nearly two-thirds.⁷⁹ These cuts were implemented despite the fact that an analysis from the legislature's own budget office showed that they would ultimately lead to an increase in the state's Medicaid budget of more than \$200 million.⁸⁰ The projected increase in Medicaid spending is more than triple the amount that the state is saving on the family planning cuts. Governor Chris Christie (R) has also recently eliminated all state family planning funding in New Jersey.⁸¹ And in Indiana, Governor Mitch Daniels (R) signed a bill into law that eliminated funding for organizations (such as Planned Parenthood) that provide both family planning services and abortions. In June of 2011, however, a U.S. district judge granted a temporary injunction against the Indiana law's enforcement, effectively reinstating Planned Parenthood's funding for the time being. The judge ruled that the state law violated Medicaid patients' freedom to use the health care provider of their choice.⁸² The matter is now before a federal appeals court.⁸³ A similar injunction is presently in place in Kansas, where Governor Sam Brownback (R) signed into law a bill stripping Planned Parenthood of family planning funds.⁸⁴ As in Indiana, this issue is still being adjudicated in Kansas.⁸⁵

79. See Thanh Tan et al., *Planned Parenthood Struggles After State Budget Cuts*, TEX. TRIB., Oct. 16, 2011, available at <http://www.texastribune.org/library/multimedia/planned-parenthood-budget-cuts/>.

80. Memorandum from the Legislative Budget Bd. to the Office of State Representative Dawnna Dukes, Analysis of Family Planning Reductions at the Department of State Health Services (May 5, 2011), available at <http://www.texasobserver.org/media/k2/attachments/FamilyPlanning.pdf>.

81. See Esmé E. Deprez, *Family Planning Loses Out in the Budget Brawl: Republican-Controlled States are Cutting Funding for Clinics*, BLOOMBERG BUSINESSWEEK (May 19, 2011, 5:00 PM), www.businessweek.com/magazine/content/11_22/b4230031808514.htm.

82. See Charles Wilson & Deanna Martin, *Planned Parenthood Win in Indiana: Judge Blocks Parts of Tough New Abortion Law*, HUFFINGTON POST (June 25, 2011, 12:42 AM), http://www.huffingtonpost.com/2011/06/24/planned-parenthood-indiana_n_884418.html.

83. See Scott Sarvay, *Indiana's De-funding of Planned Parenthood Heads to Federal Appeals Court*, INDIANA'S NEWSCENTER (Oct. 20, 2011, 4:38 PM), <http://www.indianasnewscenter.com/news/political-radar/Indianas-Defunding-of-Planned-Parenthood-Heads-to-Federal-Appeals-Court-132270588.html>.

84. See Mary Wisniewski, *Judge Blocks Kansas Law Aimed at Planned Parenthood*, REUTERS UK (Aug. 2, 2011, 5:24 AM), <http://uk.reuters.com/article/2011/08/02/health-us-abortion-states-kansas-idUKTRE7704FQ20110802>.

85. Family planning funding has also recently been cut in Florida, New Hampshire, North Carolina, Tennessee, and Wisconsin. See *State by State*

Given that many states are grappling with budget shortfalls, governors and legislatures may feel inclined to reduce expenditures on family planning programs rather than expand them. But the research reviewed here suggests that this is precisely the right time for strapped states to implement expansions in their Medicaid family planning services, since doing so would likely generate fiscal savings. As a group, then, federal and state policy-makers deserve a mixed report card. The Obama administration, the president's allies in Congress, and many governors and state legislators deserve credit for steering resources to proven pregnancy prevention strategies that are likely to improve the well-being of their citizenry and save their taxpayers money. However, this progress is now threatened by efforts to reduce or even eliminate key sources of family planning funding at the state and federal levels and by the reluctance of some state governments to accept federal funding for evidence-based pregnancy prevention programs. The evidence reviewed in this Essay suggests that investments in proven pregnancy prevention strategies ought to be appealing to policymakers in both parties and at all levels of government, whether their primary goal is to reduce the incidence of abortion, improve child well-being, curb rates of non-marital and teen childbearing, or reduce government spending.

VII. CONCLUSION

Unintended pregnancy has become a prominent feature of the American social landscape. This fact has important implications for children, for families, and for society at large: unintended pregnancy is associated with outcomes ranging from high school dropout and child poverty to juvenile delinquency and abortion. Reductions in the rate of unintended pregnancies have the potential to generate meaningful improvements along each of these dimensions. In this Essay, I have shown that unintended pregnancy rates declined substantially in recent years for teens but increased modestly over the same period for young adults. The central question, then, is what can be done to maintain the progress we have seen among teens and to reverse the trends observed among older women.

Fortunately, there is an extensive academic literature both on the causes of unintended pregnancy and on the likely effects of policy prescriptions aimed at reducing its incidence. With respect to the first of these two considerations, there is evidence

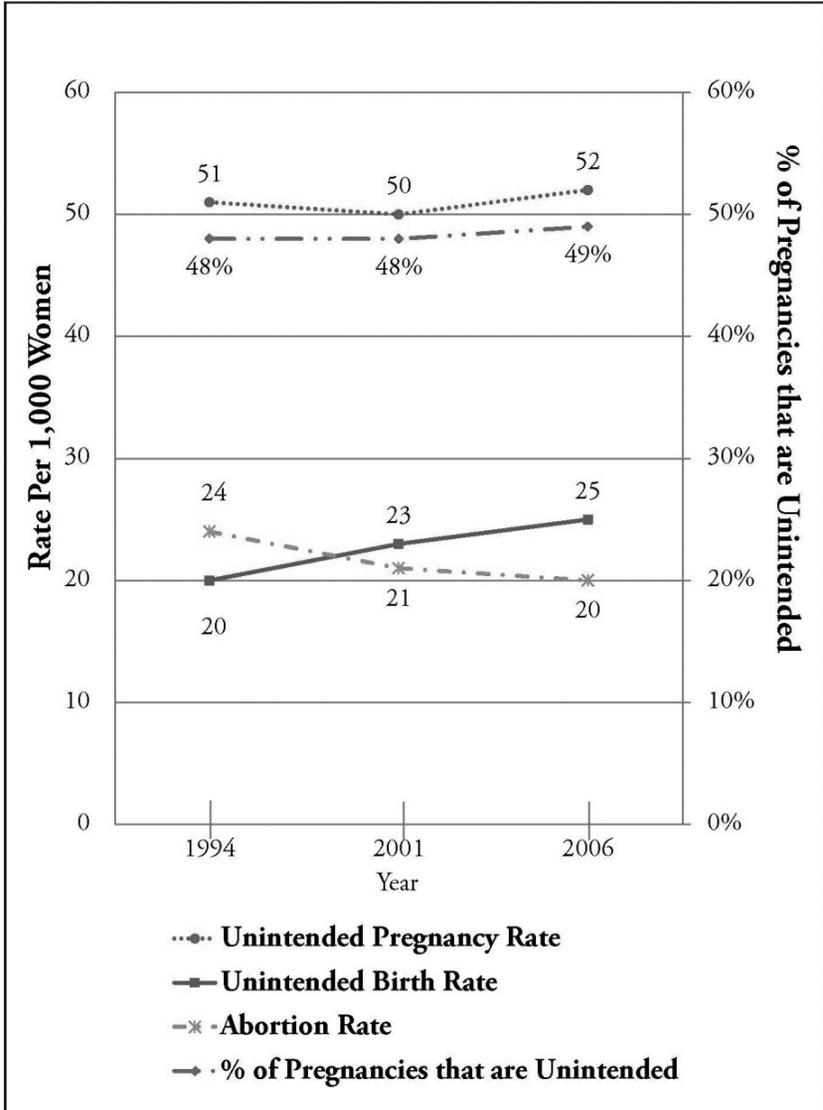
Scoreboard, SUSAN B. ANTHONY LIST, <http://www.sba-list.org/PPScoreboard> (last visited Feb. 24, 2012).

to suggest: (1) that many individuals lack the motivation to avoid unintended pregnancy; (2) that others have the best of intentions but little understanding of how to follow through on those intentions; and (3) that still others are armed with the right information and the motivation to put it to good use but have limited access to the most effective forms of contraception. There is also convincing evidence from high-quality studies showing that public policy can affect each of these root causes via interventions such as media campaigns discouraging unsafe sex, comprehensive teen pregnancy prevention programs, and expansions in government subsidies for contraceptive services. Many policymakers have made wise investments in such programs. However, other officials have declined federal funding for proven pregnancy prevention strategies or have even sought to reduce or eliminate existing sources of funding for these programs.

The politicization of this set of issues is unfortunate. Reductions in unintended pregnancy produce a variety of benefits—improved life prospects for women and children, lower rates of abortion and single parenthood, and reduced government spending—that should be appealing to partisans on both sides of the aisle. At the same time, pregnancy prevention policies ought not to be viewed as cure-alls. Many of the factors that contribute to unintended pregnancy are not directly susceptible to policy manipulation. For instance, while strategies such as media campaigns and sex education interventions may induce some individuals to engage in safer sexual behavior, there are many young men and women living at the margins of society who anticipate few, if any, meaningful returns to turning over a new leaf. As such, policies that improve public education, reduce economic inequality, and reward those who “play by the rules” are also likely to be critical pieces of this puzzle. Moving forward, it will be important that the public officials tasked with addressing our high rate of unintended pregnancy be clear-headed in their assessment of the relevant evidence, broad-minded in their development of policy solutions, and resolute in the face of political opposition. Unintended pregnancy has become a genuinely pressing problem in the United States, and a serious and sustained commitment on the part of our policymakers is required if further progress is to be made.

APPENDIX A: TRENDS IN UNINTENDED PREGNANCY & PREGNANCY OUTCOMES, BY AGE⁸⁶

FIGURE 1: TRENDS IN UNINTENDED PREGNANCY, UNINTENDED CHILDBEARING, AND ABORTION AMONG WOMEN AGED 15–44



86. Figures 1–3 based on the author’s compilation and analysis of data reported in *Finer & Zolna, supra* note 1, *Finer & Henshaw, supra* note 18, *Henshaw, supra* note 18, *Jones & Kooistra, supra* note 18, and *Kost et al., supra* note 18.

FIGURE 2: TRENDS IN UNINTENDED PREGNANCY, UNINTENDED CHILDBEARING, AND ABORTION AMONG WOMEN AGED 15-19

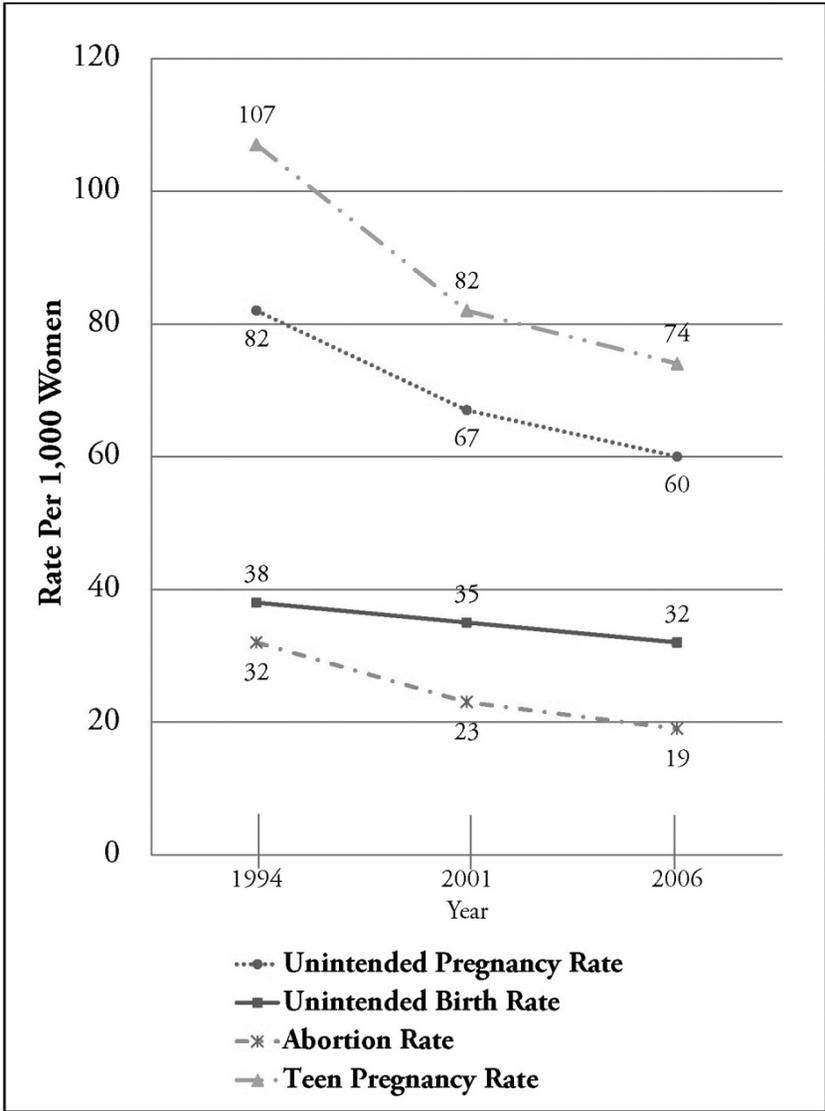
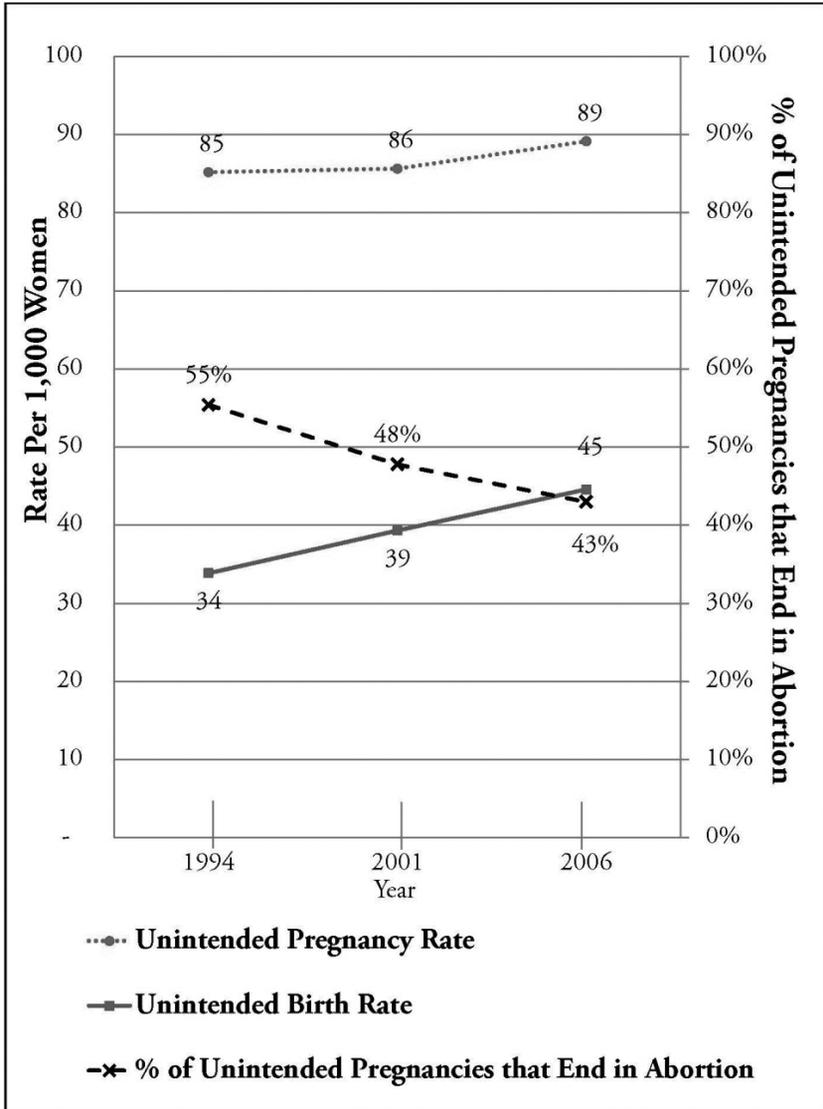
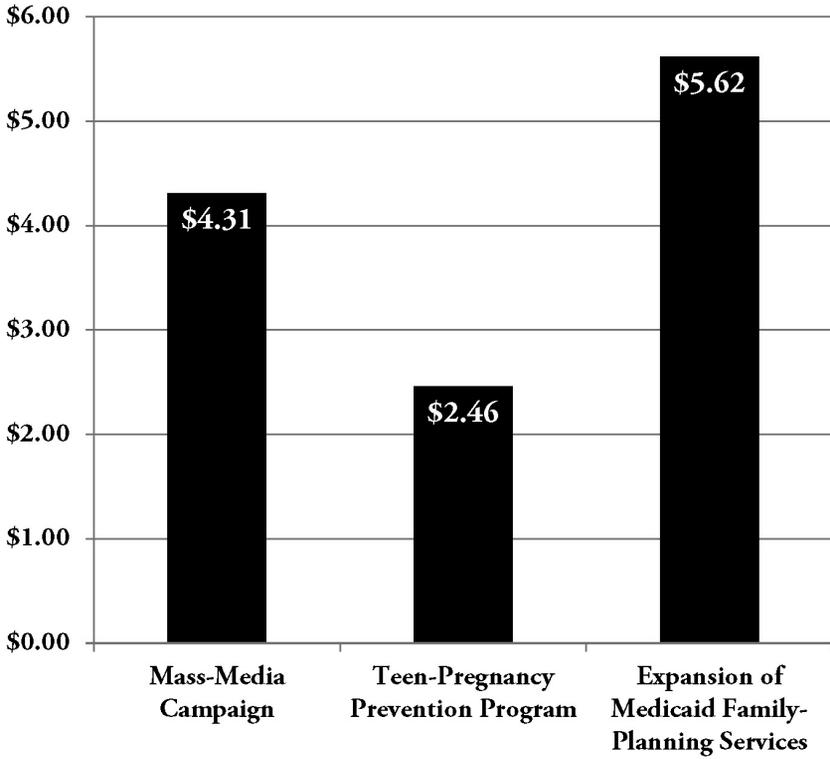


FIGURE 3: TRENDS IN UNINTENDED PREGNANCY, UNINTENDED CHILDBEARING, AND ABORTION AMONG WOMEN AGED 20-29



APPENDIX B: BENEFIT-COST RATIOS FOR THREE EVIDENCE-BASED PREGNANCY PREVENTION POLICIES⁸⁷

87. Based on an analysis of programs studied in Thomas, *supra* note 53, showing estimated taxpayer savings for every dollar spent on the three pregnancy prevention programs discussed in *supra*, Part V.

