

Hopes for Change Amidst Changing Political Realities: A Status Report on U.S. Sexual and Reproductive Health Policy

Political instability and partisan gridlock largely defined Washington during the first year of the Obama administration, and this situation may be expected to intensify in the months leading up to November's high-stakes congressional elections. Making progress of any kind on a progressive sexual and reproductive health policy agenda this year will be exceedingly difficult. Yet, in this sea of ongoing political uncertainty, it is perhaps all the more remarkable that at least some items on that agenda are, in fact, advancing. This is especially true in the cases of sex education and U.S. support for family planning and reproductive health programs overseas. Meanwhile, domestic family planning policy is basically in a holding pattern; real progress depends largely on the fate of the still-pending health care reform legislation. In stark contrast, by almost any measure, abortion rights are losing ground domestically.

Progress

The Obama administration and the new Congress teamed up over the last year to block continued federal funding for rigid abstinence-only-until-marriage programs. That process is virtually complete, with programs—the community-based abstinence-education program—terminated entirely and the Title V grants-to-states program legally expired, although social conservatives are still waging a last-ditch effort to revive in it the health care reform bill. Simply putting an end to U.S. funding for these programs,

which flourished during the Bush administration despite increasing evidence that they were ineffective, is a major accomplishment. The real step forward, however, is the creation of an alternative, evidence-based, \$114.5 million teen pregnancy prevention program, which was enacted into law just last December and is slated to grow to \$133.7 million next year under the president's budget request. The specifics of how this new program will be implemented have yet to be worked out, and important questions critical to its success remain to be answered (related article, page 2). Still, after all these years, it is a tremendous breakthrough that the federal government is at last in a position to identify and encourage the development of programs and approaches that actually work to promote and protect the health of young people.

The other area in which notable progress was made over the last year is U.S. policy and support for family planning and reproductive health programs overseas. President Obama rescinded the global gag rule during his first days in office and shortly thereafter restored a contribution to the United Nations Population Fund (UNFPA) for the first time since 2001. In terms of financial support, the United States is now contributing a total of almost \$650 million to family planning and reproductive health programs in the developing world, including \$55 million for UNFPA. Focused advocacy from nongovernmental organizations, determined

leadership in Congress and strong support from the Obama administration account for what amounts to a 40% increase in funding for the international program over the level just a little over a year ago at the end of the Bush administration. The president's budget request for about \$700 million for FY 2011 puts the United States on track toward attaining advocates' goal of \$1 billion by 2014, a goal derived from U.S. global commitments and the large, documented unmet need for services.

Going forward, U.S. effort in this area will constitute a core component of the administration's Global Health Initiative (GHI). Details are still unfolding, but simply put, the GHI seeks to maximize health outcomes through better coordination and enhanced quality of care. Priority areas include prevention of unintended pregnancy and promotion of maternal and child health, as well as prevention and treatment of HIV, malaria, tuberculosis and neglected tropical diseases. The GHI includes a pledge from the president to ramp up resources for all of these interventions together to spend just over \$60 billion over the six years ending in 2014.

Earlier this year, Secretary of State Hillary Rodham Clinton delivered a major address at the State Department commemorating the 15th anniversary of the International Conference on Population and Development. Unlike any senior administration official before her, she

made the case for how fundamental it is for a woman to be able to control her own fertility and made the connection to the broader U.S. development and foreign policy goals. “We understand there is a direct line between a woman’s reproductive health and her ability to lead a productive, fulfilling life,” she said. And “while investing in women lifts many lives, the inverse is also true. In societies where women’s rights and roles are denied, girls are forbidden from attending school or they pay a very heavy price to try to do so. Few have the right to decide whether or when to get married or become mothers. Poverty, political oppression, and even violent extremism often follow.” Accordingly, Clinton explained, the GHI is and must be central to U.S. foreign policy. “We are making it clear that there has to be special attention paid to the needs of women and girls,” she concluded, because “it’s in America’s national security interests to do so.”

Potential

On the domestic side, the status of the family planning agenda is more of a mixed bag. Last year, the president requested and Congress approved a modest increase for the Title X national family planning program of about \$10 million, bringing the current total to \$317.5 million. Despite an overall freeze on most discretionary domestic spending, the president’s budget proposal for next year includes another increase for Title X—but only another \$10 million. Meanwhile, the White House is still drafting the president’s “common ground” proposal. It is expected to address, in significant part, ways to reduce the need for abortion—but what it will actually say and what it will actually propose remains to be seen. A significant boost in funding

for Title X would go a long way toward actually reducing the need for abortion by helping women prevent unintended pregnancies, and Congress, of course, will have the opportunity to outdo the president on this front as it works its will during the annual appropriations process.

Beyond Title X, the pending health care reform legislation includes a number of provisions that together would greatly enhance access to family planning services, especially for low-income people. First and foremost, expanding private health insurance coverage in general to millions of people who do not currently have coverage, in and of itself, would correspondingly expand coverage for family planning. Beyond that, health care reform would expand Medicaid coverage—likely to all individuals with incomes under 133% of poverty but, in any case, to a level far above most states’ current Medicaid eligibility ceilings. This would provide coverage for free family planning services for millions more low-income people than have it now. In addition, the pending legislation would make it much easier for states to expand Medicaid coverage for family planning to individuals with incomes well above 133% of poverty, as 21 states have already done, without having to endure the highly burdensome and time-consuming administrative “waiver” process. This is necessary because even the near-universal coverage envisioned under the best of circumstances (which itself would only be attained after several years) would still leave many millions of people uninsured.

Health care reform also aims to ensure that people will actually have family planning providers in their health care plans, by requiring plans

to contract with “essential community providers”—defined to include community health centers, public hospitals, HIV/AIDS clinics and family planning clinics. Finally, it would lessen financial barriers to women’s preventive and screening services by including a requirement that all private insurance plans cover, without cost-sharing, a package of services to be defined by the federal government. The hope and expectation is that this would include family planning services and supplies, prenatal care, and screenings for cervical cancer and STIs. In short, health care reform—if enacted—would represent a major advance for access to family planning services in the United States.

Disappointment

With the good in health care reform legislation, though, would certainly come the bad. If supporters can free the bill from the partisan gridlock that has trapped it for months, it almost certainly will carry with it a sweeping restriction on abortion coverage in private insurance. In a perverse twist, making health insurance available to more people in order to make health care more financially accessible at the same time would create a disincentive for insurers to cover abortion at all and likely increase women’s out-of-pocket expenses to pay for abortion services.

The details of the antiabortion language in whatever health care bill may finally emerge are still in flux, but the outlines are already established. The House-passed version would effectively eliminate coverage of abortion for anyone purchasing health insurance through the health care exchanges. The Senate version would not go quite that far, but it would impose on insurers a compli-

cated and cumbersome set of procedures, including requiring subscribers to write two premium checks: one specifically for abortion coverage (although not labeled as such) and one for everything else. The bottom line is that antiabortion activists capitalized on the weak support in Congress—and the administration—for subsidizing abortion services for poor women under Medicaid, banned under the Hyde amendment, to make inroads into blocking or at least strongly discouraging abortion coverage in private insurance.

Whatever finally happens on health care reform in general and on the abortion “compromise” in particular, the politics surrounding abortion rights have been severely damaged. That said, it is noteworthy that while abortion politics were beginning to roil health care reform, Congress, with support from the administration, did for the first time in 15 years actually repeal a Hyde-type restriction by changing U.S. law to now allow the government of the District of Columbia to use its own funds to pay for abortion services under Medicaid, as all states can do. Still, with the federal

government poised to impose abortion coverage restrictions affecting middle-class women for the first time—and with many states angling to follow suit—the discouraging news is that even more women will likely be struggling over how to pay for abortion services and at what cost to their families. It can only be hoped that this new and, sadly, larger constituency will mobilize soon to awaken policymakers to the insult and injustice of U.S. abortion policy and to begin anew a campaign to turn it around.
—*Susan A. Cohen*