To: Health and Human Services Committee
From: Marion Miner, Associate Director for Pro-Life & Family
Nebraska Catholic Conference
Subject: LB 498 (Create State Contraception Program under Medicaid) (OPPOSE)
Date: February 22, 2019

Madame Chair Howard and Members of the Health and Human Services Committee,

The Nebraska Catholic Conference advocates for the public policy interests of the Catholic Church and advances the Gospel of Life by engaging, educating, and empowering public officials, Catholic laity, and the general public. I am here today to express the Conference's opposition to LB 498.

LB 498 would expand contraception coverage through Nebraska's Medicaid program. Medicaid already provides free contraception to persons who fall at or below the federal poverty level. With the passage of Medicaid expansion in Nebraska, those whose household income is up to 138% of the federal poverty level will now qualify for government-provided family planning services, including birth control.

Page 4, lines 7-12 of LB 498 provide, in part, that "the department shall submit a state plan amendment… for the purpose of providing medical assistance for family planning services for persons whose income is at or below the income eligibility level set by the state… for coverage for pregnant women." What that means in real terms and numbers is that Medicaid will provide contraception to persons who are at or below 194% of the federal poverty level. The difference between 138% and 194% of the federal poverty level for a single person in 2019 is $16,753 vs. $23,551. For a two-person household, the difference is $22,714 vs. $31,932.

There are a few reasons the Conference opposes this policy: first, numerous studies from sources across the ideological spectrum illustrate that greater access to contraception does not *reduce* unintended pregnancies and abortion, but in fact *increases* both; second, studies purporting to show that increased contraception availability decreases abortion are largely estimates and projections not based on hard data; and third, some studies have concluded that a rise in contraceptive use has been a significant factor in the breakdown of marriage, which comes with a high social cost that falls disproportionately on the poor.[1]

Two studies by the Guttmacher Institute, the research arm of Planned Parenthood, found that 48% of women with unintended pregnancies and more than half of women seeking abortions were using contraception in the month they became pregnant.[2] In addition, numerous studies examining sexual

[1] See, e.g., G. Akerlof et al., "An Analysis of Out-of-Wedlock Childbearing in the United States," The Quarterly Journal of Economics CXI (1996).
[2] Guttmacher Institute, "Abortion in Women's Lives," www.guttmacher.org/pubs/2006/05/04/AwIL.pdf, at 7; Guttmacher Institute, "Facts on Induced Abortion in the United States," July 2008, www.guttmacher.org/pubs/fb_induced_abortion.html.

behavior and STD transmission have demonstrated a greater willingness to engage in sexually risky behavior when a person believes the risk has been reduced through the use of contraception.[3] Researchers in Spain examined patterns of contraceptive use and abortion from 1997-2007 and found that a 63% increase in the use of contraceptives during that time coincided with a 108% increase in the rate of elective abortions.[4] In July 2009, results were published from a three-year program in the U.K., conducted at 54 sites, which sought to reduce teenage pregnancy through sex education and advice on access to family planning, beginning at ages 13-15. "No evidence was found that intervention was effective in delaying heterosexual experience or reducing pregnancies." In fact, young women who took part in this family planning program were more likely than those in the control group to report they had been pregnant (16% vs. 6%) and had early heterosexual experience (58% vs. 33%).[5]

Finally, a study completed in 2018 which analyzed whether oral contraceptives played a causal role in the rise of non-marital births in the United States during the twentieth century concluded that access to the pill significantly increased both non-marital births and demand for abortion, and that the effects are especially concentrated among less educated families and minority women.[6]

It is also worth pointing out that LB 498 includes coverage, without qualification, of "[a]ll United States Food and Drug Administration-approved family planning methods, including the drug or device, insertion or provision, and removal" of various forms of birth control. I note that provision because many forms of "family planning" approved by the FDA function not only to prevent pregnancy, but to terminate a pregnancy which has already begun. Hormonal birth control works in three ways: (1) by preventing ovulation; (2) by preventing fertilization if ovulation occurs; and (3) by preventing implantation of an already-fertilized zygote or embryo in the womb. This third form is an early abortion. At fertilization, a new organism with its own unique and complete set of human DNA forms and begins to grow rapidly, even before implantation. This new life, though extremely small in size, is human, has a unique and complete set of DNA, and is alive and growing. Hormonal birth control, when effective, will not only prevent pregnancy, it will end the life of a new human person. Since LB 498 allows for Medicaid coverage of all contraceptives approved by the FDA, it also allows for coverage of those contraceptives which also function as abortifacients and terminate already-existing human life.

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[3] See, e.g., J. Richens et al., "Condoms and Seat Belts: the Parallels and the Lessons," The Lancet 355 (2000): 400-403; M. Cassell et al., "Risk compensation: the Achilles' heel of innovations in HIV prevention?", British Medical Journal 332 (2006): 605-607.
[4] J. Duenas et al., "Trends in the Use of Contraceptive Methods and Voluntary Interruption of Pregnancy in the Spanish Population during 1997-2007," 83 (2011) Contraception 82-87.
[5] M. Wiggins et al., "Health Outcomes of Youth Development Programme in England: Prospective Matched Comparison Study," British Medical Journal 339.72 (2009).
[6] A. Beauchamp and C. Pakaluk, "The Paradox of the Pill: Heterogeneous Effects of Oral Contraceptive Access" (November 27, 2018). Available at SSRN: https://ssrn.com/abstract=2998268.

In conclusion, the Conference opposes LB 498 because social science has demonstrated convincingly that if the goal is to prevent unintended pregnancy and lower the rate of abortion, one of the worst things you can do is to push contraception at vulnerable populations. It increases sexually risky behavior; it increases the rate of unintended out-of-wedlock pregnancy, which has devastating effects on the poor; and it increases the rate of abortions, which has devastating effects on everyone. For these reasons, we ask that you indefinitely postpone LB 498.

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