NEBRASKA CATHOLIC CONFERENCE

To: Health and Human Services Committee
From: Marion Miner, Associate Director for Pro-Life & Family Policy
Nebraska Catholic Conference
Subject: LB67 (Allow for Provision of Contraceptives in School-Based Health Centers) (Oppose)
Date: February 18, 2021

Chairman Arch 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 LB67.

LB67 would amend portions of the Medical Assistance Act (MAA) dealing with "school-based health centers," institutions created by the Legislature in 2010 to extend some of the broadly agreed-upon benefits of Medicaid into schools.

Among other things, LB67 would strike from state law the provision that school-based health centers cannot be prescribers, dispensers, or counselors for contraception. As a practical matter, striking that provision would have at least three notable consequences.

First, it would allow school-based health centers to counsel for, prescribe, and/or dispense contraception to children at school.

Second, because it must be read in tandem with the rest of the MAA, it would require that these Medicaid-reimbursed contraceptives be advertised to schoolchildren at the beginning of each year. The MAA requires that "Each public school district shall annually, at the beginning of the school year, provide written information supplied by the department to every student describing the availability of children's health services provided under the medical assistance program." (Neb. Rev. Stat. § 68-913(1).)

Third, and most importantly, because of overlapping federal law related to Title X, school-based health centers in Nebraska would be allowed to offer contraception to children without informing parents or obtaining their consent. Most of Nebraska's school-based health centers are also Title X providers.[1] Where Title X providers offer contraception services, they are required by federal law to do so: (i) without regard to age, including to adolescent children[2]; and (ii) "confidentially"—in other words, without notifying parents unless written consent is given by the child.[3] That is something over which neither the State of Nebraska nor any school district has any control. Where Title X providers are allowed to provide contraception in schools, federal regulations dictate they must be allowed to do so free

[1] OneWorld and Charles Drew, both Title X subgrantees, operate five grade school, one middle school, and two high school SBHCs in Omaha. See https://district.ops.org/DEPARTMENTS/Student-and-Community-Services/Health-Services/School-Based-Health-Centers/Hours-and-Locations#7108430-elementary-sites. The state's other SBHC (as of 2019) is in Grand Island.
[2] 42 CFR § 59.5(a)(1) and (4); 42 USC § 300.
[3] 42 CFR § 59.11.

from parental oversight. State and local governments have tried to fight that federal requirement with parental consent laws for years, and they have lost in court when those laws were challenged.[4]

It is worth noting that numerous studies from sources across the ideological spectrum illustrate that greater access to contraception does not *reduce* unintended pregnancies and abortion, but in fact tends to *increase* both. Many of the most prominent studies purporting to show that increased contraception availability decreases abortion, on the other hand, are largely estimates and projections with little or no supporting empirical data.[5]

Two studies by the Guttmacher Institute, which receives significant funding from Planned Parenthood, found that 48% of women and girls with unintended pregnancies and more than half of those seeking abortion were using contraception in the month they became pregnant.[6] In addition, numerous studies examining sexual behavior and STD and STI 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.[7] 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.[8] 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."[9] 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 to have had early heterosexual experience (58% vs. 33%).[10]

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 and girls.[11]

In conclusion, the hard data available shows that contraceptive access does not result in later sexual experience, fewer unintended pregnancies, or fewer abortions, but tends to increase all three. LB67 would increase that access by offering it *at school*, and *without parental knowledge* or consent. The Conference respectfully asks that you indefinitely postpone the bill.

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[4] See, e.g., *County of St. Charles, Mo. v. Missouri Family Health Council*, 107 F.3d 682 (8th Cir. 1997); *Does v. Utah Dep't of Health*, 776 F.2d 253 (10th Cir. 1985); *New York v. Heckler*, 719 F.2d 1191 (2nd Cir. 1983); and *Planned Parenthood Fed. of America v. Heckler*, 712 F.2d 650 (D.C. Cir. 1983).

[5] For examples, see Michael J. New, "Analyzing the Impact of State Level Contraception Mandates on Public Health Outcomes," *Ave Maria Law Review*, Vol. 13:2, 348.

[6] 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.

[7] See, e.g., M. Cassell et al., "Risk compensation: the Achilles' heel of innovations in HIV prevention?", British Medical Journal 332 (2006): 605-607; J. Richens et al., "Condoms and Seat Belts: the Parallels and the Lessons," The Lancet 355 (2000): 400-403.

[8] 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.

[9] M. Wiggins et al., "Health Outcomes of Youth Development Programme in England: Prospective Matched Comparison Study," British Medical Journal 339.72 (2009).

[10] *Ibid.*

[11] 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.