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percent of poverty. Families pay no enrollment fee, though in some of the programs that offer drug benefits they pay a $1 to $3 copayment per prescription. To spread risk, some programs require that all eligible children in a family enroll.

The programs cover outpatient care, preventive services (well-child visits, immunizations), acute care (visits for illness, accidents) emergency services, diagnostic (lab and x-ray) services, and outpatient surgery. A few of the programs offer prescription drugs. Inpatient services are not covered. Providers are primarily physicians in the Blue Cross/Blue Shield network and hospitals for outpatient and emergency care. Physicians are generally paid their normal Blue Cross rates (often a discount off usual and customary charges).

Caring Foundations are private non-profit corporations funded through philanthropic donations. Civic groups, churches, and other organizations are encouraged to "sponsor" a child or family. All Blue Cross Associations donate administrative costs for staff and claims processing. Some also match private donations to fund the health care services, whose costs range from about $200 to $300 per child per year. The state of Iowa appropriated $300,000 in start-up funds in 1989 to match private contributions for the Caring Foundation program in that state. Blue Cross of Western Pennsylvania has the largest enrollment among Caring Foundation plans - 6,000 children (15 percent of the estimated eligible population) who remain on the program an average of about 19 months.

Because they are designed to supplement Medicaid, Caring Foundation programs require potentially eligible children to apply for Medicaid before applying to the Foundation. Through their outreach and public relations efforts, some plans have identified a large number of Medicaid-eligible children. Thus they can be an important Medicaid screening agency with which state Medicaid programs could coordinate.

Several Caring Foundation plans have begun in the last year, and it is possible that this model will spread to other states. State agencies can play a role in encouraging such programs to develop. Even if they cannot offer matching funds, they can arrange to share publicity and outreach activities. A close relationship between the Medicaid eligibility staff and the Caring Foundation staff that processes applications is important to assure that each program plays its appropriate role and that maximum federal matching is achieved in order to serve as many low income children as possible.

Modified Health Insurance Products

In its earliest form, health insurance was designed to indemnify subscribers against the costs of catastrophic illness by covering hospital, surgical, and accident benefits with a large deductible. Such catastrophic coverage plans are still available from some health insurers. For instance, Blue Cross plans in several states market a "Basic" plan of hospital, surgical, sickness and accident benefits (often with obstetrical care) with high cost sharing and lower than normal annual and lifetime limits. However, catastrophic coverage is not the norm and appears to have limited appeal, especially to employer groups, whose policies generally have

low cost sharing features, increasingly broader benefits, and generous life-time maximum and stop loss provisions. Concern about the uninsured has generated a search for lower cost insurance plans that might be more attractive to small, uninsured employers than such traditional catastrophic coverage.

Benefits Under Existing Legal Authority

A few of the Johnson Foundation demonstrations lowered insurance premiums without public subsidies by such strategies as managed care, provider discounts, or high cost sharing on inpatient services but little or no cost sharing on preventive care (See Appendix II). For instance, an HMO in **Utah** reduced premiums through managed care strategies and high copayments for acute care, while one in **Tennessee** lowered costs by deep hospital discounts. The SCOPE project in Denver offers a plan through United States Life, a large indemnity carrier, that includes both a limited provider network and cost sharing for inpatient and acute care with no copayment for preventive services. These plans cover catastrophic costs (e.g., full coverage after $2,500 in out-of-pocket expenditures on acute care) while providing first dollar coverage for preventive services that young families may need (eg. full coverage for all recommended well-child visits in the first five years of life and immunizations). Such a plan design is attractive because subscribers feel that they can use the plan[1] and are willing to pay the small additional premium for preventive benefits.

Developed specifically for currently uninsured small groups, these limited benefit products are not attractive to most currently insured firms (other than those contemplating dropping their insurance due to cost). But they fill a void in the market. They are popular and, although enrollment rates may seem modest from the viewpoint of covering the uninsured population, the insurance industry finds enrollment very encouraging. The demonstration project experience also seems to be inspiring imitation. About a year after SCOPE began marketing in the Denver area, a competitor has started marketing a similar product. Some Blue Cross plans are also developing products with coverage of specified preventive services and high deductibles. Because of high cost sharing in some of these plans, however, it could be argued that enrollees with low incomes have merely moved from the status of uninsured to underinsured.[2]

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[1]The original concept of health insurance as spreading the risk of an unexpected and potentially very costly event has changed to a mechanism for partially prepaying the costs of health care. Thus, people often express a preference for a plan that they can expect to use, even for an extra cost, rather than one that protects them against an unpredictable and costly risk.

[2]Low income SCOPE enrollees are eligible for subsidies for hospital cost sharing through Colorado's Medically Indigent program.

Insurance Regulation to Expand Coverage

Required Small Group Policies

While the limited benefit products described above are emerging in states with few mandated insurance benefits, other states are attempting to encourage non-traditional plans by explicit regulation. For instance, as part of its 1990 omnibus health care financing and insurance regulation reform bill, **Connecticut** requires all insurers writing small group products to offer "special health care plans" to any firm with under 25 employees (except firms under eleven employees, a majority of whom are low income[3]) that has been uninsured for at least two years. Payment is limited to 75 percent of Medicare's rates, and the statute requires providers to accept these rates. Insurers must pay out at least 75 percent of the premium in benefits, and premiums for these plans are not subject to the state's 2 percent premium tax.

Insurance Mandate Waivers

Over 700 different types of services (e.g., mental health, mammography), providers (e.g., chiropractors, optometrists, psychologists), or prospective enrollees (e.g., newborns, adoptive children, disabled children) are covered through insurance mandates throughout the U.S. (Gabel et al., 1989). Some of these laws merely require that the benefit be offered ("mandated offering"), but most require that the benefit be covered ("mandated coverage"). In 1990 eight states enacted laws permitting insurers to offer special products to small groups (generally 25 or fewer employees) that eliminate some of the state group insurance mandates (See Appendix I, Table C). The insurance pools in **Oregon** and **Oklahoma** (participation in which entitles employers to income tax credits discussed in Chapter V) will also develop or authorize purchase of insurance that may not include state mandates.

These laws approach the issue of alternative product design in two ways:

- Some statutes, such as that in **Missouri**, permit a carrier writing small group coverage to develop policies that eliminate such services as substance abuse, mammograms, newborn coverage, home health, or hospice care.

- Other laws (e.g., in **Rhode Island** or **Virginia**) both waive specific mandates and define the minimum benefits that must be covered, such as a given number of hospital days, physician visits, and other services. Some of these laws actually add new benefits, such as prenatal and maternity care, in order to assure that they meet the needs of the younger families likely to use them.

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[3] A newly created public reinsurance pool will offer a special health care plan to firms under ten with a majority of low wage employees; this plan is required to pay out at least 80 percent of premiums in benefits and operate on a "no gain/no loss" basis.

So far, insurers in **Washington** and **Virginia** have developed products under these laws. Premiums are estimated to be 60 percent to 70 percent of the cost of full-benefits policies. Some plans include prenatal and well child care not required by state law. The products are thus far well received (New York Times, 1990). Once again, the issue of whether these limited products are adequate depends on the design of each plan and the needs of enrollees.

As most policy makers have learned, the debate over mandated insurance benefits is highly charged. Insurers and employers resist the idea of any government mandates, contending that eliminating mandates would lower insurance prices to affordable levels. Certainly many larger firms have become self-insured to avoid the requirements of premium taxes and benefit mandates (Gabel et al., 1989).[4] Providers and constituent groups argue for maintaining and expanding insurance benefits in order to assure that needed services are affordable and to spread their costs over the largest possible population.

There is no consensus on the critical issue of the cost of these mandates or even the best method to measure their costs. While some services, such as inpatient substance abuse treatment, seem likely to add to the cost of health insurance, others, such as home care or hospice care can substitute for more expensive hospital or nursing home services (Gabel et al., 1989). Still others, such as prenatal care and mammography save longer-term health care costs (Institute of Medicine, 1985; State of Hawaii, 1990). Some benefits are also thought to add to costs because they uncover other problems that need medical attention. Laws requiring that all providers legally entitled to render a service must be reimbursed if the service is offered (e.g., requiring psychologists to be paid if mental health care is covered) probably result in covering lower cost providers but appear also to increase overall use of the service among people preferring to use non-physician practitioners (Gabel et al., 1989). Still other services, such as obstetrical or newborn care, are costly but may serve an important public policy purpose and can be much less expensive if their costs are spread over a large group of enrollees rather than just people selecting the benefit or needing the service.

Consideration of "bare-bones" policies exempt from mandated benefits provides policy-makers an opportunity to consider what services ought to be available to all citizens as well as which services to cut. Several states, including **Rhode Island, Virginia,** and **Illinois,** have taken this approach and maintained mandates for such services as coverage of newborns, adopted and disabled children; well child care; and prenatal care. Other states, however, have allowed the ax to fall on such preventive services as mammography and well-child care where there are inarguable public health benefits and at least arguable potential long-term cost savings.

Policy makers should seek objective information about the costs and benefits of these requirements. States such as **Maryland** and **Maine** have enacted laws requiring a cost-benefit analysis of any proposed additional mandates--a challenging task. The arguments about

[4] This is true despite the fact that surveys of benefits offered by self-insured firms reveal that they provide the most common mandated services, such as mental health and substance abuse (Bartlett, 1990).

mandates will be better served if an objective evaluation can be undertaken of the need for each service in question, its costs, its substitution and augmentation effects, and the opportunities for managing each type of care. Most of the research on the costs of mandated benefits has been funded by the insurance industry and has tended to examine the proportion of all claims represented by mandates, which ranges from 6 percent to 21 percent, rather than the substitution and additive effects of mandates. (Ralston et al., 1988; Gabel et al., 1989; Wisconsin Insurance Commissioner, 1990)

Fortunately, it is not necessary for policy makers to delve into the entire mandated benefits controversy to encourage more variety in the health insurance market. As discussed in Chapter IV, public agencies could fund or merely foster new insurance plan development efforts. If there is sound evidence that lower cost products cannot be developed within the state's current insurance law, consideration of mandated benefit waivers may be appropriate. Such a proposal should be based on market information about what employers and employees are interested in buying, detailed actuarial data on costs of different benefits to the target population, and public policy goals of encouraging coverage of selected services regardless of their cost impact. To facilitate employers' choices among plans and evaluate the price impact of foregone benefits, a waiver law should require, as do those in Illinois and Virginia, that insurers disclose to prospective purchasers the state's mandated benefits not covered in the limited plan and the premium savings associated with them.

LETTERS

FEB 26 1991

Asian American Perspectives

As an Asian American elected official, I appreciated the perspectives presented in Rob Gurwitt's November article, "Have Asian Americans Arrived Politically? Not Quite" [page 32].

Almost all Asian American politicians, except for those in Hawaii, are elected in districts where less than 10 percent of the population is Asian American. The candidates, therefore, feel they must be better qualified and appealing to a broad cross section of voters.

Each year, Asian American communities become more established economically, better organized and in agreement on some common Asian American issues. With this process, a framework is being formed for the Asian American community to influence the political process.

Lloyd F. Hara
City Treasurer
Seattle

I take exception to your statement that the Los Angeles suburb of Monterey Park is the nation's only city with an Asian-origin majority.

I am a longtime resident of Hawaii who just moved to Washington state. I believe the statistics will clearly show that Hawaii has an overall Asian population of about 80 percent.

Why is it that our lovely state of Hawaii is so often overlooked when comparing community statistics?

Edwyna Carole Fong
Assistant Planner
Skagit County Department of Planning and Community Development
Mount Vernon, Washington

The reference should have been to mainland cities. Hawaii state government statistics indicate that, as of 1987, 60.5 percent of Hawaiians were Asians or Pacific Islanders. Those figures, however, do not include substantial numbers of people of mixed background.

Health Insurance in Connecticut

I was disappointed in reading your November article "Health Insurance for All: A Possible Dream?" [page 56] that no mention was made of landmark legislation passed last year in Connecticut to address the problem of access to health care to the poor and employees of small businesses.

The law imposes significant reforms on the health insurance market in the state. Among other provisions, it mandates that any employer with 25 or fewer employees can obtain health insurance from any carrier in the market and that no individual employee can be excluded from coverage.

We believe the new law, which should be fully operational early this year, is the most comprehensive piece of health access legislation adopted in 1990. My company, one of the largest small-business health insurers, is pursuing similar legislation in many other states in conjunction with our national trade association, the Health Insurance Association of America.

F. Peter Libassi
Senior Vice President
The Travelers Companies
Hartford, Connecticut

Reinventing Small-Town America

The good people of Baker, Montana, are not alone as they seek to reinvent their community to compete in the world market ["A Small Town's Choice: Change, Or Fade Away," September, page 32]. Communities across the country are slowly coming to realize that they must undertake the same painful process.

It is important that communities take a long-term, comprehensive approach to community revitalization, and one that builds on local assets. Over the past 10 years, the National Main Street Center, a program of the National Trust for Historic Preservation, has helped organize local revitalization programs in more than 660 communities (average population: 23,000) in 31 states.

We've seen more than 51,000 new jobs created in these communities, along with 15,000 new businesses and 21,000 building rehabilitation projects. We have recently begun to work in communities with populations under 5,000—at 468 people, Bonaparte, Iowa, is our smallest Main Street town. At present, 51 small communities in seven states are successfully applying the Main Street approach to revitalization.

Kennedy Smith
Acting Director
National Main Street Center
Washington, D.C.

Write to the National Main Street Center in care of the National Trust for Historic Preservation, 1785 Massachusetts Ave. N.W., Washington, D.C. 20036. Phone (202) 673-4000.

I was struck by Rob Gurwitt's cover story in your September issue on efforts by community leaders in Baker, Montana, to invent a new economic future for the town. He managed to convey the poignance of Baker's predicament while also conveying the grit and hopefulness of its leaders. A program administered here at the University of Minnesota also deals on a daily basis with that same grit and hopefulness, focusing on Minnesota, Montana and North and South Dakota.

The aim of the W.K. Kellogg Public Policy Program, which is funded by the W.K. Kellogg Foundation, is to reach out to the kind of local leaders you identified in Baker and to bring them up-to-the-minute information on a wide variety of rural development issues so that they are better equipped to make policy decisions.

In the 18 months we've been in operation, we have sponsored seminars and conferences on such topics as rural education, rural economic development, the Canada-U.S. Free Trade Agreement, agricultural policy and rural health care policy.

The sparse population of the four states our program covers means that local governments have little (and decreasing) resources, and participants in our conferences often have to travel vast distances to attend. What keeps

Employee Retirement ... of 1974

§ 1002. Definitions

For purposes of this title:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 [29 USCS § 186(c)] (other than pensions on retirement or death, and insurance to provide such pensions).

(2)(A) Except as provided in subparagraph (B), the terms "employee pension benefit plan" and "pension plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that by its express terms or as a result of surrounding circumstances such plan, fund, or program—

(i) provides retirement income to employees, or

(ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond,

regardless of the method of calculating the contributions made to the plan, the method of calculating the benefits under the plan or the method of distributing benefits from the plan.

(B) The Secretary may by regulation prescribe rules consistent with the standards and purposes of this Act providing one or more exempt categories under which—

(i) severance pay arrangements, and

(ii) supplemental retirement income payments, under which the pension benefits of retirees or their beneficiaries are supplemented to take into account some portion or all of the increases in the cost of living (as determined by the Secretary of Labor) since retirement,

shall, for purposes of this title, be treated as welfare plans rather than pension plans. In the case of any arrangement or payment a principal effect of which is the evasion of the standards or purposes of this Act applicable to pension plans, such arrangement or payment shall be treated as a pension plan.

(3) The term "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.

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To Melissa | From Mike Fox
Co. | Co.
Dept | Phone #
Fax # | Fax #

(4) The term "employee organization" means any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any employees' beneficiary association organized for the purpose in whole or in part, of establishing such a plan.

(5) The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

(6) The term "employee" means any individual employed by an employer.

(7) The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

(8) The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

(9) The term "person" means an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization.

(10) The term "State" includes any State of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, and the Canal Zone. The term "United States" when used in the geographic sense means the States and the Outer Continental Shelf lands defined in the Outer Continental Shelf Lands Act (43 U.S.C. 1331–1343).

(11) The term "commerce" means trade, traffic, commerce, transportation, or communication between any State and any place outside thereof.

(12) The term "industry or activity affecting commerce" means any activity, business, or industry in commerce or in which a labor dispute would hinder or obstruct commerce or the free flow of commerce, and includes any activity or industry "affecting commerce" within the meaning of the Labor Management Relations Act, 1947, or the Railway Labor Act.

(13) The term "Secretary" means the Secretary of Labor.

(14) The term "party in interest" means, as to an employee benefit plan—

(A) any fiduciary (including, but not limited to, any administrator, officer, trustee, or custodian), counsel, or employee of such employee benefit plan;

(B) a person providing services to such plan;

(C) an employer any of whose employees are covered by such plan;

(D) an employee organization any of whose members are covered by such plan;

(E) an owner, direct or indirect, of 50 percent or more of—

(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of a corporation.

(ii) the capital interest or the profits interest of a partnership, or

(iii) the beneficial interest of a trust or unincorporated enterprise,

which is an employer or an employee organization described in subparagraph (C) or (D);

(F) a relative (as defined in paragraph (15)) of any individual described in subparagraph (A), (B), (C), or (E);

(G) a corporation, partnership, or trust or estate of which (or in which) 50 percent or more of—

(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of such corporation,

(ii) the capital interest or profits interest of such partnership, or

(iii) the beneficial interest of such trust or estate,

is owned directly or indirectly, or held by persons described in subparagraph (A), (B), (C), (D), or (E);

(H) an employee, officer, director (or an individual having powers or responsibilities similar to those of officers or directors), or a 10 percent or more shareholder directly or indirectly, of a person described in subparagraph (B), (C), (D), (E), or (G), or of the employee benefit plan; or

(I) a 10 percent or more (directly or indirectly in capital or profits) partner or joint venturer of a person described in subparagraph (B), (C), (D), (E), or (G).

The Secretary, after consultation and coordination with the Secretary of the Treasury, may by regulation prescribe a percentage lower than 50 percent for subparagraph (E) and (G) and lower than 10 percent for subparagraph (H) or (I). The Secretary may prescribe regulations for determining the ownership (direct or indirect) of profits and beneficial interests, and the manner in which indirect stockholdings are taken into account. Any person who is a party in interest with respect to a plan to which a trust described in section 501(c)(22) of the Internal Revenue Code of 1986 [26 USCS § 501(c)(22)] is permitted to make payments under section 4223 [29 USCS § 1403] shall be treated as a party in interest with respect to such trust.

(15) The term "relative" means a spouse, ancestor, lineal descendant, or spouse of a lineal descendant.

(16)(A) The term "administrator" means—

(i) the person specifically so designated by the terms of the instrument under which the plan is operated;

(ii) if an administrator is not so designated, the plan sponsor; or

(iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe.

(B) The term "plan sponsor" means (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

(17) The term "separate account" means an account established or maintained by an insurance company under which income, gains, and losses, whether or not realized, from assets allocated to such account, are, in accordance with the applicable contract, credited to or charged against such account without regard to other income, gains, or losses of the insurance company.

(18) The term "adequate consideration" when used in part 4 of subtitle B [29 USCS §§ 1101 et seq.] means (A) in the case of a security for which there is a generally recognized market, either (i) the price of the security prevailing on a national securities exchange which is registered under section 6 of the Securities Exchange Act of 1934 [15 USCS § 78f], or (ii) if the security is not traded on such a national securities exchange, a price not less favorable to the plan than the offering price for the security as established by the current bid and asked prices quoted by persons independent of the issuer and of any party in interest; and (B) in the case of an asset other than a security for which there is a generally recognized market, the fair market value of the asset as determined in good faith by the trustee or named fiduciary pursuant to the terms of the plan and in accordance with regulations promulgated by the Secretary.

(19) The term "nonforfeitable" when used with respect to a pension benefit or right means a claim obtained by a participant or his beneficiary to that part of an immediate or deferred benefit under a pension plan which arises from the participant's service, which is unconditional, and which is legally enforceable against the plan. For purposes of this paragraph, a right to an accrued benefit derived from employer contributions shall not be treated as forfeitable merely because the plan contains a provision described in section 203(a)(3) [29 USCS § 1053(a)(3)].

(20) The term "security" has the same meaning as such term has under section 2(1) of the Securities Act of 1933 (15 U.S.C. 77b(1)).

(21)(A) Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting

management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 405(c)(1)(B) [29 USCS § 1105(c)(1)(B)].

(B) If any money or other property of an employee benefit plan is invested in securities issued by an investment company registered under the Investment Company Act of 1940, such investment shall not by itself cause such investment company or such investment company's investment adviser or principal underwriter to be deemed to be a fiduciary or a party in interest as those terms are defined in this title, except insofar as such investment company or its investment adviser or principal underwriter acts in connection with an employee benefit plan covering employees of the investment company, the investment adviser, or its principal underwriter. Nothing contained in this subparagraph shall limit the duties imposed on such investment company, investment adviser, or principal underwriter by any other law.

(22) The term "normal retirement benefit" means the greater of the early retirement benefit under the plan, or the benefit under the plan commencing at normal retirement age. The normal retirement benefit shall be determined without regard to—

(A) medical benefits, and

(B) disability benefits not in excess of the qualified disability benefit.

For purposes of this paragraph, a qualified disability benefit is a disability benefit provided by a plan which does not exceed the benefit which would be provided for the participant if he separated from the service at normal retirement age. For purposes of this paragraph, the early retirement benefit under a plan shall be determined without regard to any benefit under the plan which the Secretary of the Treasury finds to be a benefit described in section 204(b)(1)(G) [29 USCS § 1054(b)(1)(G)].

(23) The term "accrued benefit" means—

(A) in the case of a defined benefit plan, the individual's accrued benefit determined under the plan and, except as provided in section 204(c)(3) [29 USCS § 1054(c)(3)], expressed in the form of an annual benefit commencing at normal retirement age, or

(B) in the case of a plan which is an individual account plan, the balance of the individual's account.

The accrued benefit of an employee shall not be less than the amount determined under section 204(c)(2)(B) [29 USCS § 1054(c)(2)(B)] with respect to the employee's accumulated contribution.

(24) The term "normal retirement age" means the earlier of—

(A) the time a plan participant attains normal retirement age under the plan, or

(B) the later of—

(i) the time a plan participant attains age 65, or

(ii) the 5th anniversary of the time a plan participant commenced participation in the plan.

(25) The term "vested liabilities" means the present value of the immediate or deferred benefits available at normal retirement age for participants and their beneficiaries which are nonforfeitable.

(26) The term "current value" means fair market value where available and otherwise the fair value as determined in good faith by a trustee or a named fiduciary (as defined in section 402(a)(2) [29 USCS § 1102(a)(2)]) pursuant to the terms of the plan and in accordance with regulations of the Secretary, assuming an orderly liquidation at the time of such determination.

(27) The term "present value", with respect to a liability, means the value adjusted to reflect anticipated events. Such adjustments shall conform to such regulations as the Secretary of the Treasury may prescribe.

(28) The term "normal service cost" or "normal cost" means the annual cost of future pension benefits and administrative expenses assigned, under an actuarial cost method, to years subsequent to a particular valuation date of a pension plan. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(29) The term "accrued liability" means the excess of the present value, as of a particular valuation date of a pension plan, of the projected future benefit costs and administrative expenses for all plan participants and beneficiaries over the present value of future contributions for the normal cost of all applicable plan participants and beneficiaries. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(30) The term "unfunded accrued liability" means the excess of the accrued liability, under an actuarial cost method which so provides, over the present value of the assets of a pension plan. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(31) The term "advance funding actuarial cost method" or "actuarial cost method" means a recognized actuarial technique utilized for establishing the amount and incidence of the annual actuarial cost of pension plan benefits and expenses. Acceptable actuarial cost methods shall include the accrued benefit cost method (unit credit method), the entry age normal cost method, the individual level premium cost method, the aggregate cost method, the attained age normal cost method, and the frozen initial liability cost method. The terminal funding cost method and the current funding (pay-as-you-go) cost method are not acceptable actuarial cost methods. The Secretary of the Treasury shall issue regulations to further define acceptable actuarial cost methods.

(32) The term "governmental plan" means a plan established or maintained for its employees by the Government of the United States, by the

government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing. The term "governmental plan" also includes any plan to which the Railroad Retirement Act of 1935 or 1937 applies, and which is financed by contributions required under that Act and any plan of an international organization which is exempt from taxation under the provisions of the International Organizations Immunities Act (59 Stat. 669).

(33)(A) The term "church plan" means a plan established and maintained (to the extent required in clause (ii) of subparagraph (B)) for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code of 1986 [26 USCS § 501].

(B) The term "church plan" does not include a plan—

(i) which is established and maintained primarily for the benefit of employees (or their beneficiaries) of such church or convention or association of churches who are employed in connection with one or more unrelated trades or businesses (within the meaning of section 513 of the Internal Revenue Code of 1986 [26 USCS § 513]), or

(ii) if less than substantially all of the individuals included in the plan are individuals described in subparagraph (A) or in clause (ii) of subparagraph (C) (or their beneficiaries).

(C) For purposes of this paragraph—

(i) A plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches includes a plan maintained by an organization, whether a civil law corporation or otherwise, the principal purpose or function of which is the administration or funding of a plan or program for the provision of retirement benefits or welfare benefits, or both, for the employees of a church or a convention or association of churches, if such organization is controlled by or associated with a church or a convention or association of churches.

(ii) The term employee of a church or a convention or association of churches includes—

(I) a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry, regardless of the source of his compensation;

(II) an employee of an organization, whether a civil law corporation or otherwise, which is exempt from tax under section 501 of the Internal Revenue Code of 1986 [26 USCS § 501] and which is controlled by or associated with a church or a convention or association of churches; and

(III) an individual described in clause (v).

(iii) A church or a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code

of 1986 [26 USCS § 501] shall be deemed the employer of any individual included as an employee under clause (ii).

(iv) An organization, whether a civil law corporation or otherwise, is associated with a church or a convention or association of churches if it shares common religious bonds and convictions with that church or convention or association of churches.

(v) If an employee who is included in a church plan separates from the service of a church or a convention or association of churches or an organization, whether a civil law corporation or otherwise, which is exempt from tax under section 501 of the Internal Revenue Code of 1986 [26 USCS § 501] and which is controlled by or associated with a church or a convention or association of churches, the church plan shall not fail to meet the requirements of this paragraph merely because the plan—

(I) retains the employee's accrued benefit or account for the payment of benefits to the employee or his beneficiaries pursuant to the terms of the plan; or

(II) receives contributions on the employee's behalf after the employee's separation from such service, but only for a period of 5 years after such separation, unless the employee is disabled (within the meaning of the disability provisions of the church plan or, if there are no such provisions in the church plan, within the meaning of section 72(m)(7) of the Internal Revenue Code of 1986 [26 USCS § 72(m)(7)] at the time of such separation from service.

(D)(i) If a plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code of 1986 [26 USCS § 501] fails to meet one or more of the requirements of this paragraph and corrects its failure to meet such requirements within the correction period, the plan shall be deemed to meet the requirements of this paragraph for the year in which the correction was made and for all prior years.

(ii) If a correction is not made within the correction period, the plan shall be deemed not to meet the requirements of this paragraph beginning with the date on which the earliest failure to meet one or more of such requirements occurred.

(iii) For purposes of this subparagraph, the term "correction period" means—

(I) the period ending 270 days after the date of mailing by the Secretary of the Treasury of a notice of default with respect to the plan's failure to meet one or more of the requirements of this paragraph; or

(II) any period set by a court of competent jurisdiction after a final determination that the plan fails to meet such requirements,

or, if the court does not specify such period, any reasonable period determined by the Secretary of the Treasury on the basis of all the facts and circumstances, but in any event not less than 270 days after the determination has become final; or

(III) any additional period which the Secretary of the Treasury determines is reasonable or necessary for the correction of the default,

whichever has the latest ending date.

(34) The term "individual account plan" or "defined contribution plan" means a pension plan which provides for an individual account for each participant and for benefits based solely upon the amount contributed to the participant's account, and any income, expenses, gains and losses, and any forfeitures of accounts of other participants which may be allocated to such participant's account.

(35) The term "defined benefit plan" means a pension plan other than an individual account plan; except that a pension plan which is not an individual account plan and which provides a benefit derived from employer contributions which is based partly on the balance of the separate account of a participant—

(A) for the purposes of section 202 [29 USCS § 1052], shall be treated as an individual account plan, and

(B) for the purposes of paragraph (23) of this section and section 204 [29 USCS § 1054], shall be treated as an individual account plan to the extent benefits are based upon the separate account of a participant and as a defined benefit plan with respect to the remaining portion of benefits under the plan.

(36) The term "excess benefit plan" means a plan maintained by an employer solely for the purpose of providing benefits for certain employees in excess of the limitations on contributions and benefits imposed by section 415 of the Internal Revenue Code of 1986 [26 USCS § 415] on plans to which that section applies, without regard to whether the plan is funded. To the extent that a separable part of a plan (as determined by the Secretary of Labor) maintained by an employer is maintained for such purpose, that part shall be treated as a separate plan which is an excess benefit plan.

(37)(A) The term "multiemployer plan" means a plan—

(i) to which more than one employer is required to contribute,

(ii) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and

(iii) which satisfies such other requirements as the Secretary may prescribe by regulation.

(B) For purposes of this paragraph, all trades or businesses (whether or not incorporated) which are under common control within the meaning of section 4001(b)(1) [29 USCS § 1301(b)(1)] are considered a single employer.

(C) Notwithstanding subparagraph (A), a plan is a multiemployer plan on and after its termination date if the plan was a multiemployer plan under this paragraph for the plan year preceding its termination date.

(D) For purposes of this title, notwithstanding the preceding provisions of this paragraph, for any plan year which began before the date of the enactment of the Multiemployer Pension Plan Amendments Act of 1980 [enacted Sept. 26, 1980], the term "multiemployer plan" means a plan described in section 3(37) of this Act [para. (37) of this section] as in effect immediately before such date.

(E) Within one year after the date of the enactment of the Multiemployer Pension Plan Amendments Act of 1980 [enacted Sept. 26, 1980], a multiemployer plan may irrevocably elect, pursuant to procedures established by the corporation and subject to the provisions of sections 4403 [4303](b) and (c) [29 USCS § 1453(b) and (c)], that the plan shall not be treated as a multiemployer plan for all purposes under this Act or the Internal Revenue Code of 1954 [26 USCS §§ 1 et seq.] if for each of the last 3 plan years ending prior to the effective date of the Multiemployer Pension Plan Amendments Act of 1980—

(i) the plan was not a multiemployer plan because the plan was not a plan described in section 3(37)(A)(iii) of this Act [para. (37)(A)(iii) of this section] and section 414(f)(1)(C) of the Internal Revenue Code of 1954 [26 USCS § 414(f)(1)(C)] (as such provisions were in effect on the day before the date of the enactment of the Multiemployer Pension Plan Amendments Act of 1980 [enacted Sept. 26, 1980]); and

(ii) the plan had been identified as a plan that was not a multiemployer plan in substantially all its filings with the corporation, the Secretary of Labor and the Secretary of the Treasury.

(F)(i) For purposes of this title a qualified football coaches plan—

(I) shall be treated as a multiemployer plan to the extent not inconsistent with the purposes of this subparagraph; and

(II) notwithstanding section 401(k)(4)(B) of the Internal Revenue Code of 1986 [26 USCS § 401(k)(4)(B)], may include a qualified cash and deferred arrangement.

(ii) For purposes of this subparagraph, the term "qualified football coaches plan" means any defined contribution plan which is established and maintained by an organization—

(I) which is described in section 501(c) of such Code [26 USCS § 501(c)];

(II) the membership of which consists entirely of individuals who primarily coach football as full-time employees of 4-year colleges or universities described in section 170(b)(1)(A)(ii) of such Code [26 USCS § 170(b)(1)(A)(ii)]; and

(III) which was in existence on September 18, 1986.

(38) The term "investment manager" means any fiduciary (other than a trustee or named fiduciary, as defined in section 402(a)(2) [29 USCS § 1102(a)(2)])—

(A) who has the power to manage, acquire, or dispose of any asset of a plan;

(B) who is (i) registered as an investment adviser under the Investment Advisers Act of 1940 [15 USCS §§ 80b-1 et seq.]; (ii) is a bank, as defined in that Act [15 USCS §§ 80b-1 et seq.]; or (iii) is an insurance company qualified to perform services described in subparagraph (A) under the laws of more than one State; and

(C) has acknowledged in writing that he is a fiduciary with respect to the plan.

(39) The terms "plan year" and "fiscal year of the plan" mean, with respect to a plan, the calendar, policy, or fiscal year on which the records of the plan are kept.

(40)(A) The term "multiple employer welfare arrangement" means an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained—

(i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements, or

(ii) by a rural electric cooperative.

(B) For purposes of this paragraph—

(i) two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group,

(ii) the term "control group" means a group of trades or businesses under common control,

(iii) the determination of whether a trade or business is under "common control" with another trade or business shall be determined under regulations of the Secretary applying principles similar to the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 4001(b) [29 USCS § 1301(b)], except that, for purposes of this paragraph, common control shall not be based on an interest of less than 25 percent, and

(iv) the term "rural electric cooperative" means—

(I) any organization which is exempt from tax under section 501(a) of the Internal Revenue Code of 1986 [26 USCS § 501(a)] and which is engaged primarily in providing electric service on a mutual or cooperative basis, and

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(II) any organization described in paragraph (4) or (6) of section 501(c) of the Internal Revenue Code of 1986 [26 USCS § 501(c)(4) or (6)] which is exempt from tax under section 501(a) of such Code [26 USCS § 501(a)] and at least 80 percent of the members of which are organizations described in subclause (I).

(41) Single-employer plan. The term "single-employer plan" means an employee benefit plan other than a multiemployer plan.

(Sept. 2, 1974, P. L. 93-406, Title I, Subtitle A, § 3, 88 Stat. 832; Sept. 26, 1980, P. L. 96-364, Title III, §§ 302, 305, Title IV, §§ 407(a), 409, 94 Stat. 1291, 1294, 1303, 1307; Jan. 14, 1983, P. L. 97-473, Title III, § 302(a), 96 Stat. 2612; Apr. 7, 1986, P. L. 99-272, Title XI, § 11016(c)(1), 100 Stat. 273; Oct. 21, 1986, P. L. 99-509, Title IX, Subtitle C, § 9203(b)(1), 100 Stat. 1979; Oct. 22, 1986, P. L. 99-514, Title XVIII, Subtitle A, Ch 7, § 1879(u)(3), 100 Stat. 2913; Dec. 22, 1987, P. L. 100-202, § 136(a), 101 Stat. 1329-441; Dec. 19, 1989, P. L. 101-239, Title VII, Subtitle G, Part V, Subpart B, § 7871(b)(2), Subpart C, § 7881(m)(2)(D), Subpart D, §§ 7891(a)(1), 7893(a), 7894(a)(1)(A), (2)(A), (3), (4), 103 Stat. 2435, 2444, 2445, 2447, 2448.)

HISTORY; ANCILLARY LAWS AND DIRECTIVES

References in text:

"This title", referred to in this section, is Title I of Act Sept. 2, 1974, P. L. 93-406, 88 Stat. 832, popularly known as the Employee Retirement Income Security Act of 1974, which appears generally as 29 USCS § 1001-§ 1168. For full classification of this Title, consult USCS Tables volumes.

"This Act", referred to in this section, is the Employee Retirement Income Security Act of 1974, Act Sept. 2, 1974, P. L. 93-406, 88 Stat. 829, which appears generally as 29 USCS §§ 1001 et seq. For full classification of this Act, consult USCS Tables volumes.

"The Outer Continental Shelf Lands Act", referred to in this section, is Act Aug. 7, 1953, ch 345, 67 Stat. 462, which is generally classified to 43 USCS §§ 1331 et seq. For full classification of this Act, consult USCS Tables volumes.

"The Labor Management Relations Act, 1947", referred to in this section, is Act June 23, 1947, ch 120, 61 Stat. 136, and appears generally as 29 USCS §§ 141 et seq. For full classification of such Act, consult USCS Tables volumes.

"The Railway Labor Act", referred to in this section, is Act May 20 1926, ch 347, 44 Stat. 577, and appears generally as 45 USCS §§ 151 et seq. For full classification of such Act, consult USCS Tables volumes.

"The Investment Company Act of 1940", referred to in this section, is Act Aug. 22, 1940, ch 686, Title I, 54 Stat. 789, and appears generally as 15 USCS §§ 80a-1 et seq. For full classification of such Act, consult USCS Tables volumes.

"The Railroad Retirement Act of 1935 or 1937" or "that Act", referred to in this section, is Act Aug. 29, 1935, ch 812, 49 Stat. 867, as amended generally by Act June 24, 1937, ch 382, Part 1, 50 Stat.

STATE OF ALASKA
THE LEGISLATURE

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Mary Van Nimwegen

4-19-91 Senate Labor & Commerce 8:12 a.m.

SB
248

STATE OF ALASKA
1991 LEGISLATIVE SESSION

Bill Version: SENATE BILL 248
Publish Date: 4/12/91

REQUEST: FISCAL NOTE

Revision Date:
Agency Affected: Health & Social Serivces
Title: Early intervention services for certain young children & families
BRU: Community Developmental Disabilities Grants
Sponsor: Zharoff, Collins
Components: Respite Care
Requester: Senate HES

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants, Claims			650.0	800.0	950.0	1,200.0
Miscellaneous						
TOTAL OPERATING	0.0	0.0	650.0	800.0	950.0	1,200.0

CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0

REVENUE	0.0	0.0	0.0	0.0	0.0	0.0

FUNDING: (Thousands of Dollars)

	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
General Funds/MHT	0.0	0.0	650.0	800.0	950.0	1,200.0
Federal Funds						
Other						
TOTAL	0.0	0.0	650.0	800.0	950.0	1,200.0

POSITIONS

	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
Full-Time		0	0	0	0	0
Part-Time		0	0	0	0	0
Temporary		0	0	0	0	0

ANALYSIS: (attach a separate page if necessary)

See Attached

Prepared By: Margaret Lowe, Director
Phone: 465-3370
Division: MENTAL HEALTH & DEVEL. DISABILITIES
Date: 04/18/91

Approved By Commissioner: Theodore Mala, M.D., MPH
Date:
Agency: HEALTH & SOCIAL SERVICES

Distribution (by preparer):
Legislative Finance, Legislative Sponsor, Requestor,
Office of Management & Budget, Impacted Agency(ies)

Senate Bill 248

Fiscal Note

Respite care services offered by the Division of Mental Health and Developmental Disabilities are part of the interagency system of services in SB 248. However, a small percentage of families eligible for services under SB 248 do not meet the Division's developmental disabilities eligibility criteria. These funds would provide respite services for those families who qualify for services under SB 248, but do not meet the criteria for respite services in the Division of Mental Health and Developmental Disabilities.

STATE OF ALASKA
1991 LEGISLATIVE SESSION

Bill Version: SENATE BILL 248
Publish Date: 4/12/91

REQUEST: FISCAL NOTE

Revision Date:
Title: Early intervention services for certain young children & families
Sponsor: Zharoff, Collins
Requester: Senate HES

Agency Affected: Health & Social Serivces
BRU: State Health Serivces
Components: Maternal, Child & Family Health

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
Personal Services			235.0	336.0	437.0	538.0
Travel			26.0	31.0	36.0	41.0
Contractual		100.0	250.0	400.0	550.0	700.0
Supplies						
Equipment						
Land & Structures						
Grants, Claims						
Miscellaneous						
TOTAL OPERATING	0.0	100.0	511.0	767.0	1,023.0	1,279.0

CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0

REVENUE	0.0	0.0	0.0	0.0	0.0	0.0

FUNDING: (Thousands of Dollars)

General Funds/MHT	0.0	100.0	511.0	767.0	1,023.0	1,279.0
Federal Funds						
Other						
TOTAL	0.0	100.0	511.0	767.0	1,023.0	1,279.0

POSITIONS

Full-Time		0	4	6	7	9
Part-Time		0	0	0	0	0
Temporary		0	0	0	0	0

ANALYSIS: (attach a separate page if necessary)

See Attached.

Prepared By: Peter M. Nakamura, MD, MPH, Director
Division: PUBLIC HEALTH
Phone: 465-3090
Date: 04/18/91

Approved By Commissioner: Theodore Mala, M.D., MPH
Agency: HEALTH & SOCIAL SERVICES
Date:

Distribution (by preparer):
Legislative Finance, Legislative Sponsor, Requestor,
Office of Management & Budget, Impacted Agency(ies)

Senate Bill 248

Fiscal Note

These funds include increases for a number of programs in the system needed to meet the needs of this population. For example, these programs include the infant learning program, public health nursing and maternal, child health services in the Handicapped Children's Program. Full implementation includes providing basic ILP services, evaluations, and all identified services needed by the child and family.

The total cost for full implementation will be less than the projected costs once private insurance, sliding fee scales and all medicaid reimbursements are taken into consideration.

Personal services costs include several public health nursing positions, and limited fiscal personnel to obtain full reimbursement from medicaid, private insurance and other billable sources, which will significantly defray costs.

Travel costs include the costs necessary to serve increased numbers of families in villages and remote areas as well as monitoring and technical assistance for local programs.

Contractual costs include purchasing medical and therapy services for children and families. The grants line includes funds for infant learning programs in unserved areas and to reduce wait lists.

STATE OF ALASKA
1991 LEGISLATIVE SESSION

Bill Version: SENATE BILL 248
Publish Date: 4/12/91

REQUEST: FISCAL NOTE

Revision Date:
Agency Affected: Health & Social Serivces
Title: Early intervention services for certain young children & families
BRU: State Health Scrivces
Sponsor: Zharoff, Collins
Components: Infant Learning
Requester: Senate HES

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants, Claims		3,000.0	4,250.0	5,500.0	6,750.0	8,000.0
Miscellaneous						
TOTAL OPERATING	0.0	3,000.0	4,250.0	5,500.0	6,750.0	8,000.0
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE	0.0	0.0	0.0	0.0	0.0	0.0

FUNDING: (Thousands of Dollars)

	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
General Funds/MHT	0.0	3,000.0	4,250.0	5,500.0	6,750.0	8,000.0
Federal Funds						
Other						
TOTAL	0.0	3,000.0	4,250.0	5,500.0	6,750.0	8,000.0

POSITIONS

	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
Full-Time		0	0	0	0	0
Part-Time		0	0	0	0	0
Temporary		0	0	0	0	0

ANALYSIS: (attach a separate page if necessary)

See Attached

Prepared By: Peter M. Nakamura, MD, MPH, Director
Phone: 465-3090
Division: PUBLIC HEALTH
Date: 04/18/91

Approved By Commissioner: Theodore Mala, M.D., MPH
Date: 4/18/91
Agency: HEALTH & SOCIAL SERVICES

Distribution (by preparer):
Legislative Finance, Legislative Sponsor, Requestor,
Office of Management & Budget, Impacted Agency(ies)

Senate Bill 248

Fiscal Note

These funds include increases for a number of programs in the system needed to meet the needs of this population. For example, these programs include the infant learning program, public health nursing and maternal, child health services in the Handicapped Children's Program. Full implementation includes providing basic ILP services, evaluations, and all identified services needed by the child and family.

The total cost for full implementation will be less than the projected costs once private insurance, sliding fee scales and all medicaid reimbursements are taken into consideration.

Personal services costs include several public health nursing positions, and limited fiscal personnel to obtain full reimbursement from medicaid, private insurance and other billable sources, which will significantly defray costs.

Travel costs include the costs necessary to serve increased numbers of families in villages and remote areas as well as monitoring and technical assistance for local programs.

Contractual costs include purchasing medical and therapy services for children and families. The grants line includes funds for infant learning programs in unserved areas and to reduce wait lists.

SENATOR FRED F. ZHAROFF

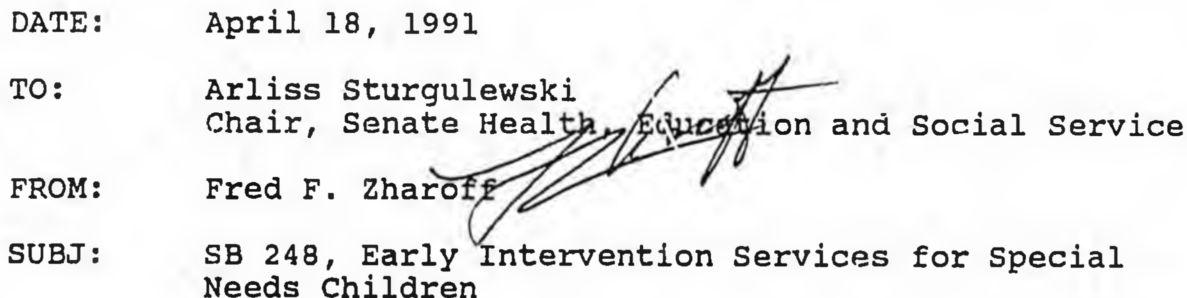
ALASKA STATE LEGISLATURE

P. O. BOX 405, KODIAK, ALASKA 99615 (907) 486-5259
DURING SESSION:
P. O. BOX V, JUNEAU, ALASKA 99811 • (907) 465-3473 • 465-3474

DISTRICT N

ALASKA PENINSULA • ALEUTIAN CHAIN • BRISTOL BAY • KODIAK ISLAND • LAKE CLARK/LAKE ILIAMNA • PRIBILOF ISLANDS • SHUMAGIN ISLANDS

MEMORANDUM



DATE: April 18, 1991

TO: Arliss Sturgulewski
Chair, Senate Health, Education and Social Service

FROM: Fred F. Zharoff

SUBJ: SB 248, Early Intervention Services for Special Needs Children

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I would like to request that a hearing for SB 248, Early Intervention Services for Special Needs Children be scheduled in the Health, Education and Social Services Committee at your earliest possible convenience. My staff requested a fiscal note and position statement from the Department of Health and Social Services on April 15, 1991, and it should be available very soon.

Enclosed is a Sectional Analysis on SB 248. My staff will forward the fiscal note and position statement when they are received.

Sectional Analysis
Senate Bill 248
Early Intervention Services for Special Needs Children

__Section 1:__ Findings. Approximately six percent of the children under the age of three in Alaska experience developmental delays or disabilities, and another 4 percent are at risk. Existing programs, for the most part, address the problems after they occur, rather than stressing prevention and early intervention. Early intervention has been proven effective in reducing or even eliminating long-term effects and costs to society of these disabling conditions. There is a need in the state for a coordinated program to provide these early intervention services to children under the age of three, and their families, who experience these problems. Provision of these services can help enable these children to remain in their home environment, minimize the potential need for institutionalization and reduce the long-term educational costs to the state by minimizing the need for special education and related services after children who experience developmental delays or disabilities reach school age.

__Section 2:__ This section amends AS 47.20 as follows:

Sec. 47.20.060 states the purpose which is to provide quality learning and related early intervention family support services for children under the age of three who have developmental delays or disabilities. At the same time to make the best use of available federal, state, local, and private resources for the benefit of these children and their families by creating a comprehensive plan for the provision of these services.

Sec. 47.20.070 will establish the program through a cooperation of the Department of Health and Social Services and the Governor's Council for the Handicapped and Gifted. The Department will develop a state plan for providing services, establish educational programs to disseminate information about the nature and effects of developmental delays and disabilities, organize and encourage training of personnel and provide for transition of the children from the early intervention program to the formal education system.

Sec. 47.20.090 provides that the department will establish a system for locating children and their families who are eligible for the services. In addition the Department will ensure that a comprehensive evaluation is done of the child and the needs of the family with the goal of both providing assistance to the family unit and making the best use of the family as a resource.

Sec 47.20.100 establishes criteria for the development of individualized family service plans. These plans will include case management and evaluations of both the child and family situation. It will specify the services that will be utilized, the projected outcomes, and the predicted dates of implementation and completion.

Sec 47.20.110 indicates that the Department will adopt regulations necessary to implement this chapter, including due process and data compiling systems.

Sec 47.20.290 provides the definitions that will be used.

Section 3: Amends AS47.80.900 to provide a more comprehensive definition of "person with a handicap", to broaden the definition to include "exceptional children", persons with developmental disabilities, and those with various physical and emotional disabilities.

Section 4: repeals AS 47.20.005, .010, .020 and .050, the Exceptional Children Program. The Early Intervention Services for Special Needs Children program will make use of the existing infrastructure and reorganize to incorporate the definitions and recommendations that have come from the work of the Governor's Council for the Handicapped and Gifted.

Section 5: provides for an effective date of July 1, 1991.

POSITION PAPER/Department of Health and Social Services

Senate Bill No. 248

For An Act entitled: " An Act relating to early intervention services for certain young children and their families; and providing for an effective date ."

Summary
This bill amends AS 47.20, Exceptional Children and AS 47.80 Persons with Handicaps. Section 1, Findings, is added and includes the urgent and substantial need to: support the development of children under the age of three with disabilities; reduce the stress on families of children with disabilities; recognize the strengths, diversity and importance of parents and families in young children's lives; encourage parent-to-parent support; reduce the likelihood of institutionalization; and reduce the long term educational costs by minimizing the need for special education.

Section 2, Subsection 060, Purpose, is added and includes: family support; bringing together and making optimal use of federal, state, local and private resources; and expanding the availability of services. Subsection 070, Establishment of Program, is added and includes the establishment and coordination of a statewide system of interagency programs which will: provide appropriate services to the eligible population; educate the public; organize and encourage training programs for service providers; and facilitate transitions between programs in the interagency system. Subsection 080, Program Eligibility, is added and includes children under the age of three who experience a developmental delay or disability, and their families. If the needs of children with delays or disabilities are met, children who are at risk for disabilities or delays will be served with available funds. Subsection 090, Finding and Evaluating Eligible Participants, is added and includes: a comprehensive system for finding children and families in need of services and providing evaluations to determine the extent and nature of those needs. Subsection 100, Individual Family Service Plan, is added to include the development of individualized family service plans and for case management services to assist families in obtaining services from the interagency system. Subsection 110, Other Duties of the Department, is added to include the adoption of regulations regarding: personnel development; resolution of interagency and intra-agency disputes; provisions for due process with respect to the rights of children and parents; the compiling of data. Subsection 290, Definitions, is added and includes definitions for: department; developmentally delayed; disability; and early intervention services.

Section 3. AS 47.80.900 (6) Persons with Handicaps, is amended to remove the reference to AS 47.20.050, which is repealed.

AS 47.20.005, Purpose, is repealed and replaced by Section 2 subsection 060.

AS 47.20.020, Assistance authorized, is repealed and replaced by Section 2 subsection 070.

AS 47.20.020, Standards for assistance, is repealed.

AS 47.20.050, Definitions, is repealed and replaced by Section 2, subsection 290.

Discussion

The interagency system of early intervention services proposed in this bill includes services provided by both the public and private sector. In addition to the Section of Maternal, Child and Family Health's Infant Learning Programs, Public Health Nursing, Division of Family and Youth Services, Division of Mental Health and Developmental Disabilities, Department of Education , Division of Corporations, private physicians, hospitals and other private providers of services are among the individuals and agencies comprising the interagency system of services. The intent of providing early intervention services to families of young children who experience developmental delays or disabilities is to provide support to the family to help maintain the family unit in their community of choice, and to help maximize the child's potential to lead an independent productive life.

The infant learning programs provide services to families of children, ages birth to three, who experience disabilities or developmental delays. These services are provided in the families home and community. The infant learning program works with the family to develop services which will assist the family in meeting their child's development needs.

If there is no infant learning program available to work with the child and family, the burden on the family as well as other, already stressed, systems in Public Health Nursing, Division of Family and Youth Services and other agencies are increased. Without the backup of infant learning programs to work directly with children and their parents, many of whom have fetal alcohol or other drug related syndromes, the social service and other health systems must pick up the full burden of providing services with their existing staff and resources.

Although there are 24 Infant Learning Programs (ILPs) in Alaska, there are several regions that do not have access to any ILP services. Many existing programs are unable to serve all the communities located in their catchment area. Due to staff shortages in many regions of the state, children who have been referred to programs may be placed on long wait lists or may not receive services at all. There are currently 388 infants and toddlers who experience developmental delays or disabilities in the

state who are on wait lists or live in areas where no infant learning services are available.

The coordination required for the provision of services through the interagency system proposed in HB 191 will result in a more efficient utilization of the existing resources. The expansion of the early intervention system, including infant learning program services to all areas of the state, will provide families in villages with access to services and will help reduce the wait list for services in urban areas. The Department has responsibility for providing many of the services included in the interagency system. The expansion of infant learning programs statewide will help ensure that the system is coordinated with the private sector and that the services needed by young children with disabilities and their families are provided in a timely and cost effective manner.

Recommendation
The Department supports this bill which will provide equal access across the state to a system of services for one of our most vulnerable groups of children and families.

Recommended: ______________________ Date: 4/18/91
Peter M. Nakamura, MD, MPH
Director
Division of Public Health

Approved: ______________________ Date: 4/18/91
for Theodore A. Mala, MD, MPH
Commissioner
Department of Health
and Social Services

SB
249

SB249

Alaska State Legislature
Representative Niilo Koponen

Pouch V
Juneau, Alaska 99811
(907) 465-4992

House District 21

119 N. Cushman, Suite 207
Fairbanks, Alaska 99701
(907) 456-8172

October 5, 1991

Senator Arliss Sturgulewski
3111 C Street
Anchorage, AK 99503

Dear Senator Sturgulewski and Staff:

Niilo asked me to send several items of information that I collected from the Mosaic for Choice Conference in Atlanta. I have a lot of items that you have not received and now I have a lot of resources where I can turn to, to receive even more information! I have also sent similar information to Representative Bettye Davis and when I return from vacation, I will continue to send information to other Legislators that may be interested in this subject.

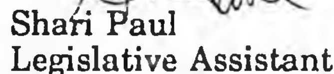
One point that I am trying to emphasis to individuals that I talk to is the importance of submitting pro-active legislation versus reactive. The Minnesota Women's Groups have implemented this route and have been very successful. As you skim through the various pieces of papers that I have included, you will find many other subjects that need to be tackled. Education in my eyes is the key in all aspects of reproductive health.

I wanted to share this information with you and your staff hoping that you will discuss submitting pertinent legislation or even organize a series Children's Caucus to discuss these issues etc. I will be happy to help out in any area that you request. Ileen Self in Anchorage will also be happy to talk with your office.

I have also included part of the conference agenda. If there is any other information that looks interesting to you, please drop me a note and I will either be able to discuss it with you or direct you to where you can locate more information.

Thanks for taking the time to review this information.

Sincerely,



Shari Paul
Legislative Assistant

A MOSAIC FOR

A National
Conference for
State Pro-Choice
Coalitions

Choice

SEPT. 27-29

a conference to strengthen coalitions to secure reproductive freedom

Hilton at Peachtree Corners
Norcross, Georgia

Ms. Foundation for Women

THE NATIONAL WOMEN'S FUND

Welcome to the first national conference for pro-choice coalitions.

The work you are engaged in is of monumental importance. The right to choose --when, where, with whom and if-- to have children is as fundamental as the right to free speech.

While, I am sorry to not be with you, I celebrate that there are enough of us now to divide the work with many strong and clear voices to speak courageously and well.

Actually, you who are engaged in these historical efforts daily are the source of the best information and strategy, and my regret is at not being there to learn more from you.

In Sisterhood,

Gloria Steinem

141 Fifth Avenue, 6S, New York, NY 10010 (212) 353-8580 fax: (212) 475-4217

AGENDA

Friday, September 27, 1991

11:00 - 1:00 **Registration** .... Pre-function Area

1:00 - 2:00 **Mosaic for Choice: Welcome and Introductions** .... Ballroom A & E
Welcome by Lynne Randall, chair of Georgians for Choice. Mary Hickey, coordinator of Georgians for Choice, will give participants an opportunity to introduce themselves to the conference.

2:00 - 3:00 **General Session: Mosaic for Choice** .... Ballroom A & E
"Coast to Coast: Who We Are", Marie Wilson, executive director of the Ms. Foundation for Women will describe the range of coalition work across the country, including the territories. "Who We Can Become" is the topic for Byllye Avery, founding president of the National Black Women's Health Project who will set the stage for the work that lies ahead.

3:00 - 3:15 **Break** .... Pre-function Area

3:15 - 4:45 **Workshops**

1. Getting Money to Get Going .... Cobb
Ellen A. Mazer, formerly with Mgt. Consultants in Chicago, will teach people in new and emerging coalitions how to develop a long range fundraising plan. How do you resolve the tension between the coalition's financial needs and those of the member organizations? How much do you need to get up and staffed? What fundraising techniques have worked and why?

2. Keeping Our Doors Open .... DeKalb
Cathy Boardman, Wisconsin Religious Coalition for Abortion Rights; Ann Baker, 80% Majority Campaign; and Carol Wayman, Washington DC Area Clinic Defense Task Force, will describe their efforts to keep clinics open, accessible and safe for patients seeking abortions. They will describe the methodology and tactics of those groups working to close down clinics, including the effect their actions have on the rest of the community and the evolution of "fake clinics."

3. Working in a Coalition: There Is No Choice .... Fulton
Ginny Montes, National Organization for Women; Jeanne Connell, Arizona Reproductive Health Coalition; Patricia Jessen, Wyoming State Coalition for Choice; and Phyllis Wynn, Delaware Coalition for Choice will describe models of successful coalitions and discuss board development and management. They will describe the rise of state coalitions as a key vehicle for winning political power.

4. Focus on Minors .... Medlock Auditorium
Jeanette Turk, campaign manager Washington YES on 120 Campaign; Cathy Flynn, Illinois Caucus on Teenage Pregnancy; and Edythe Harrison, founder Virginia Pro-Choice Alliance, will discuss messages, messengers and strategies that led to the defeat or passage of parent notice initiatives. The panelists will describe how these efforts are a part of the larger anti-abortion strategy and the prospects for teenage girls' access to abortion services.

5. Changing the Face of the Legislature .... Ballroom C
Polly Rothstein, director of Westchester Coalition for Legal Abortion, will offer a comprehensive overview of the voter identification strategy which helped elect pro-choice candidates to all levels of office. It will include nuts and bolts of a voter id project and touch on educating and activating voters. Rothstein is the "mother of voter id," having pioneered the process in her home county with stunning success.

4:45 - 5:00 **Break** .... Pre-function Area

5:00 - 6:00 **Caucuses**

1. Women of Color .... Cobb
Facilitated by Julia R. Scott, NBWHP, for women of color only, please.

2. Staff of Coalitions .... DeKalb
Facilitated by Mary Hickey, for paid and volunteer staff

3. **Board Leadership** .... Fulton
Facilitated by Lynne Randall, chair of Georgians for Choice

4. **Lobbyists** .... Ballroom D
Facilitated by Carolyn Pardue, for paid and volunteer lobbyists

5. **AIDS Organizing** .... Ballroom C
Facilitated by Helen Rodriquez-Trias

7:00 PM **Bus Leaves for Tour of Atlanta and Underground** .... Lobby
Join us for a tour on a double-decker bus for the sights of Atlanta including the Dr. Martin Luther King Center and the Carter Center. The bus will stop at Underground Atlanta where guests can cruise for a bite to eat and people watch. We will return by 11:00 pm.

Saturday, September 28, 1991

8:00 - 8:30 **Continental Breakfast** .... Pre-function Area

8:30 - 10:30 **General Session: Exploring What Choice Means to Diverse Communities** .... Ballroom A & E
Julia R. Scott, director of the Washington, DC Public Policy/Education Office of the National Black Women's Health Project, will lead a panel of women who will each discuss how "choice" is translated in her community, what unique issues arise in organizing women of color, poor women and differently abled around the issue of reproductive freedom. Joining her on the panel are: Luz Alvarez-Martinez, Lois Hartel, Margine Sako, Norma Scheurkogal, and Patricia Tyson

10:30 - 10:45 **Break** .... Pre-Function Area

10:45 - 12:15 **Workshops**

6. **Networking: Casting the Strongest Net** .... Cobb
Rebecca Tillet, of the National Women's Political Caucus; Judith Schoap, Oregon-NARAL; and Luz Alvarez-Martinez, Latinas for Reproductive Health, will examine the cause and effect of networking to gain the maximum organizational strength for coalitions. They will explore some tools of networking, such as regional conferences, and ways to implement them.

7. **Stopping Them Isn't Enough: Pro-Active Strategies** .... Ballroom C
Janice Steinschneider, Center for Policy Alternatives, will facilitate this panel which includes Mylan Hawkins, "Campaign for Choice" in Nevada; Diane Sands, Montana Women's Lobby; and Amy Phenix, Planned Parenthood of Minnesota. Since Webster, there has been an upsurge in the number of pro-choice bills filed in state legislatures. This workshop will explore the possibilities and pitfalls of legislative and ballot measures and provide an overview of pro-active options.

8. **How the Supreme Court Is Turning Back the Clock** .... Fulton
Kitty Kolbert, ACLU Reproductive Freedom Project, and Joanne L. Hustead, Women's Legal Defense Fund, two of the leading experts on the Supreme Court's rulings and justices, will have a dialogue on recent actions taken by the Supreme Court and their repercussions. Do we assume that the end of Roe v. Wade is in sight? Do we move our attentions away from Washington and concentrate on our states?

9. **Birth Control: Under Whose Control** .... Ballroom D
Maggie Bangser, the Asian Program Officer of the International Women's Health Coalition will moderate a panel which includes Julia R. Scott, of the National Black Women's Health Project, and Helen Rodriquez-Trias, founder of the Committeee to End Sterilization Abuse. The workshop will explore how new technologies of fertility control do and do not work for us; the need to broaden discussion of fertility control to issues of drug addiction and HIV among women; and the international impact of US policy on fertility control and abortion in southern countries.

10. Choice Is the Message:
Using Radio, TV and Print to Educate the Public .... Medlock Auditorium
Tamar E. Abrams is a media consultant to Planned Parenthood Federation of America and was previously Communications Director for NARAL. She will talk about how to use the media to get your message out, how to deal with bad media, and how to hone your message. She will also discuss how the opposition uses the media; what the media is looking for from the pro-choice side and how to develop free media strategies to compensate for the lack of a big media budget.

12:15 - 12:30 Pick Up Box Lunch .... Pre-function Area

12:30 - 2:00 **Regional Caucuses / Lunch**

1. Northeast .... Pool Area
2. Southeast .... Mingles
3. Midwest .... Tortugas
4. West .... Ballroom D

2:00 - 3:30 **Workshop Sessions**

1. Getting Money to Keep Going .... Cobb
The focus of this workshop shifts to coalitions who are older than three years and are experiencing the "blah's". How do you attract new money to your old coalition? What happens when you are a victim of your own success and everyone thinks you're doing great and don't need them?

2. Keeping Our Doors Open .... Fulton
(see earlier description)

3. Working in a Coalition: There Is No Choice .... DeKalb
(see earlier description)

4. Focus on Minors .... Medlock Auditorium
(see earlier description)

5. Changing the Face of the Legislature .... Ballroom C
(see earlier description)

3:30 - 3:45 Break .... Pre-function Area

3:45 - 5:15 **Workshop Sessions**

6. Networking: Casting the Strongest Net .... Cobb
(see earlier description)

7. Stopping Them Isn't Enough: Pro-Active Strategies .... Ballroom C
(see earlier description)

8. How the Supreme Court Is Turning Back the Clock .... Fulton
(see earlier description)

9. Birth Control Under Whose Control .... Ballroom D
(see earlier description)

10. Choice Is the Message:
Using Radio, TV and Print to Educate the Public .... Medlock Auditorium
(see earlier description)

AGENDA

6:00 - 7:00 **Evening Reception (Cash Bar)** .... **Ballroom A & E**
Celebrating Pro-Choice Legislators

7:00 - 9:00 **Dinner with Dr. M. Joycelyn Elders as Guest Speaker** .... **Ballroom A & E**
Dr. Elders, the director of the Arkansas Department of Health, has been successful in making contraceptives available to students through their schools and consequently reducing teenage pregnancy dramatically. She will have much to tell us.

Sunday, September 29, 1991

8:00 - 8:30 **Continental Breakfast** .... **Pre-function Area**

8:30 - 10:00 **General Session: "National and State Connections: How We Are Going to Get There Together"** .... **Ballroom A & E**
Susan Dickler, advisor to the Ms. Foundation, will facilitate a panel of representatives from the leading pro-choice organizations, who will discuss how state organizations can best rally to actions at the federal level and how these national organizations can best serve the needs of the grassroots. These national leaders will also share how they define the role of coalitions in their national strategies. Panelists will include Bob Bingaman, NARAL; Joanne Blum, Planned Parenthood; Alice Cohan, NOW; and Kitty Kolbert, ACLU Reproductive Freedom Project.

10:00 - 10:15 **Break** .... **Pre-function Area**

10:15 - 11:45 **Workshops**

1. **Getting Money to Get Going** .... **Cobb**
   (repeat of the Friday workshop)

3. **Working in a Coalition: There is No Choice** .... **DeKalb**
   (see earlier description)

5. **Changing the Face of the Legislature** .... **Fulton**
   (see earlier description)

7. **Stopping Them Isn't Enough: Pro-active Strategies** .... **Ballroom D**
   (see earlier description)

9. **Birth Control Under Whose Control** .... **Ballroom C**
   (see earlier description)

Noon - 2:00 **Closing Session:**
"Preparing for the Long Haul: Coalitions Plan for the Future" .... **Ballroom B**
A panel of coalition leaders will discuss steps that must be taken to ensure our survival over the long haul. How to expand the agenda for reproductive rights. How to include members of diverse communities, women of color, rural women, poor women. How to institutionalize our networks and grassroots support. How to become more sensitive, more sophisticated and more self-confident that we are going to win. Panelists include: Bisola Marignay, Illinois Pro-Choice Alliance; Peggy Romberg, Texans for Choice; Jeanette Turk, Pro-Choice Washington, and Leslie Gerwin, Louisiana Coalition for Reproductive Freedom.

. . . and open mike session,
facilitated by Georgia Rep. Nan Orrock "Where Do We Go From Here . . ."

Collaborative Project on State Reproductive Health Policy

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September, 1991

Dear Mosaic for Choice Participant:

When the Supreme Court handed down its July, 1989 decision in *Webster v. Reproductive Health Services*, it thrust the states into the forefront of the nation's battle over reproductive choice. State policy has assumed a critical role in determining whether American women will have the right to choose.

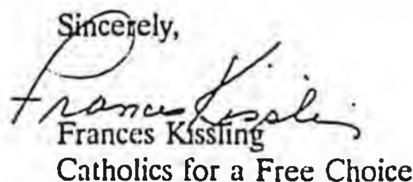
Five national pro-choice organizations came together in 1989 and formed the Collaborative Project on State Reproductive Health Policy, in order to support pro-choice state leaders in their work and to insure that all women have access to full reproductive choice. We provide a range of assistance, policy analysis, coalition building strategy and message development, sharing information and experiences among states.

The Collaborative Project is committed to a broad reproductive choice agenda which includes abortion rights. It goes beyond abortion, however. Women need access to safe, effective contraception, prenatal care and information about reproductive health issues, as well as access to safe, legal abortion, to be fully empowered to make decisions about whether to have children.

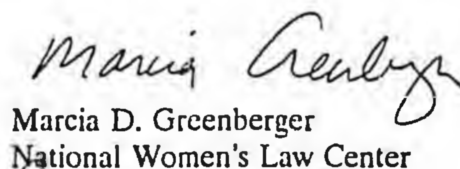
This collection of materials was prepared by the five member organizations of the Collaborative Project on State Reproductive Health Policy. It provides information on some of the elements of a broad reproductive choice agenda. A description of project activities and organizations is also included.

If we can be of help to you in your work, please contact Janice Steinschneider at (202)387-6030 or any of the members of the Collaborative Project.

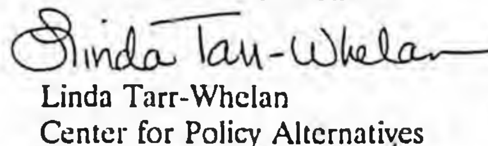
Sincerely,



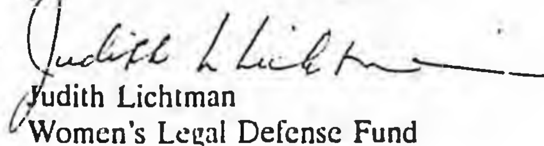
Frances Kissling
Catholics for a Free Choice



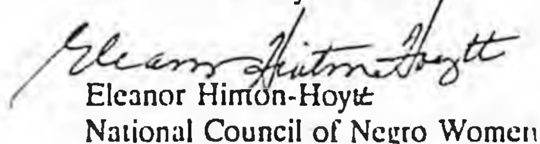
Marcia D. Greenberger
National Women's Law Center



Linda Tarr-Whelan
Center for Policy Alternatives



Judith Lichtman
Women's Legal Defense Fund



Eleanor Hinton-Hoytt
National Council of Negro Women

A project of the Center for Policy Alternatives

Contact: Janice Steinschneider, Senior Program Attorney

printed on recycled paper

Collaborative Project on State Reproductive Health Policy

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DESCRIPTION OF THE COLLABORATIVE PROJECT

The Collaborative Project on State Reproductive Health Policy is a joint venture of five, non-profit, non-partisan organizations based in Washington, DC. These organizations are:

- **Catholics for a Free Choice**
- **Center for Policy Alternatives**
- **National Council of Negro Women**
- **National Women's Law Center**
- **Women's Legal Defense Fund**

The Center for Policy Alternatives serves as the project's managing associate.

Purpose of the Collaborative Project

The project's purpose is to promote full reproductive health choices for women and their families by ensuring their access, regardless of income, to:

- safe, effective contraception and abortion and
- maternal and infant health programs.

The project accomplishes this goal by providing intensive technical assistance to pro-choice leaders -- legislators, policymakers and advocates -- in selected states, helping them identify and evaluate the range of policy options on reproductive choice issues of particular importance in their state.

Collaborative Project Activities

On the invitation of pro-choice leaders in a state, who will function as a host committee, the collaborative project will develop and implement a two-day information sharing session for pro-choice legislators, officials and advocates. The information-sharing session will consist of a series of meetings, briefings and workshops around
such issues as reproductive choice policy options, pro-choice constituency building, the media's treatment of reproductive choice issues, and public education and awareness.

The host committee and collaborative project organizations will work together to:

- identify the most pressing issues and needs in that particular state;
- select participants for the information session and follow up on invitations;
- select the most convenient place and time; and
- devise an effective format for the information-sharing session.

♦ Contact yellow page authorities to request a new, separate listing for "abortion alternatives."

♦ Educate interested groups in the community on the nature and scope of the problem.

♦ Alert newspapers and other media to the issue.

2. Litigation by Private Parties and the State

♦ All 50 states and the District of Columbia have laws prohibiting false, deceptive or misleading advertising. These laws may authorize suits by consumers, competitors and the state attorneys general, and permit injunctive relief, damages and attorneys' fees.

♦ In North Dakota, Texas, California and New York, consumer fraud laws have been used by the state, consumers, and abortion and family planning organizations to successfully stop fake abortion clinics and the Pearson Foundation from continuing deceptive practices. Damages and attorneys' fees have also been awarded.

♦ State action, including both administrative enforcement and litigation, can be an important tool in combating the fake abortion clinic problem. State action may be the only practical way of remedying abuses as private parties may not have the resources to engage in litigation. Also, state action reflects the state's obligation to protect consumers from deceptive practices. Moreover, state action can result in state-wide, rather than case-specific resolution of the fake clinic problem. Finally, state action puts the weight and authority of the state behind the importance of the problem, sending a message to fake abortion clinics, organizations like the Pearson Foundation, and the public that the deceptive tactics of fake abortion clinics will not be tolerated.

3. Legislative Action

Legislative action has included public hearings and legislation. Legislators in some states have not pursued legislation because in their view no new laws are needed in light of legal precedent which supports action against fake clinics under existing consumer fraud laws.

♦ Public hearings before state legislatures and city councils have provided a forum for legislators to conduct a full-scale inquiry into the fake abortion clinic issue including: the nature and scope of the problem; the kind of harm experienced by women and by legitimate clinics; what state agencies have done to protect the public under existing consumer fraud laws; the reasons for inaction by state authorities; and the need if any for new legislation.

♦ In Wisconsin, a 1989 Senate resolution on fake abortion clinics was introduced. It defined certain fake clinic practices as deceptive, and urged the attorney general to investigate all fake abortion clinic complaints.

♦ In Ohio, legislators added a fake clinic-specific amendment to the Ohio consumer fraud law, making clear that the deceptive practices of fake abortion clinics violated the law.

Prepared by: Katherine Connor
Marcia D. Greenberger

Collaborative Project on State Reproductive Health Policy

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TOWARDS A BROAD REPRODUCTIVE CHOICE AGENDA:
An Issues Reader

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2. CATHOLICS FOR A FREE CHOICE
   - Actions Speak Louder: A Look at Congressional Votes on Human Life Issues
   - Capturing the Middle: A Message Strategy for the Pro-Choice Movement in the Post-Webster Era
3. CENTER FOR POLICY ALTERNATIVES
   - CHOICE: One Voting Issue, A Multifaceted Agenda
   - Legislating Full Reproductive Choice: Examples From the States
4. NATIONAL COUNCIL OF NEGRO WOMEN
   - Fact Sheet: Women of Color and Reproductive Health
5. NATIONAL WOMEN'S LAW CENTER
   - Selected Initiatives for Improving Maternal and Child Health
   - Fake Abortion Clinics: Executive Summary *
   - Medicaid Funding of Abortion
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   - School Based Clinics and Prevention of Adolescent Pregnancy *
   - Drug-Dependent Pregnant Women: Executive Summary *

*For information about obtaining the full articles, contact Janice Steinschneider at (202) 387-6030.

POLICY ALTERNATIVES ON

Reproductive Choice

—a state report

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VI. Mobile Prenatal Care Services Combat Infant Mortality
VII. Essay by Frances Kissling: *If War Is 'Just,' So Is Abortion*
VIII. Resources
IX. Choice News Clips

Edited by Janice Steinschneider

Summer, 1991

Vol. 2., No. 2

CENTER FOR POLICY ALTERNATIVES

1875 Connecticut Ave N.W. Suite 710 Wash D.C. 20009

A Newsjournal
of Prochoice
Catholic Opinion

Vol. XII, No. 4
July/August 1991

CONSCIENCE

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Packaging Feminism for the Abortion Debate

by Mary E. Hunt

The nation's Catholic bishops did prochoice Catholics a favor when they signed a multi million-dollar contract with the New York public relations firm Hill and Knowlton. Scandalized by this misappropriation of church funds, rank-and-file Catholics who would prefer to see such monies go into sex education and birth control got a glimpse of how the bishops operate. Most were not edified by what they saw.

Hill and Knowlton has made the bishops' strategy quite obvious. It seems these P.R. people have urged the bishops to become feminists just like us, except with an antichoice slant. Their sleight of hand has not passed unnoticed. They rely heavily on the notion of "Feminists for Life," simultaneously the name of a nineteen-year-old organization—headquartered in Kansas City, MO, with a reported 2,500 members last year—and an umbrella term for those persons (I assume men can be feminists) who oppose abortion. I am more interested in the issue than the organization because it is issues and not individuals or even groups that are at stake.

In responding to "feminists for life" and the National Conference of Catholic Bishops' (NCCB) campaign, it is important to separate ideology from public relations, distinguish principles from propaganda. Theology, after all, is not advertising. My guess is that, if Catholics for a Free Choice had hired Hill and Knowlton, the firm would have given us advice similar to what it gave to the bishops. Advisors would have suggested that we

(See Packaging Feminism, *page 3)*

CONSCIENCE

A Newsjournal of Prochoice Catholic Opinion

Catholics for a Free Choice (CFFC) is a national educational organization that supports the right to legal reproductive health care, especially family planning and abortion. CFFC also works to reduce the incidence of abortion and to increase women's choices in childbearing and childrearing through advocacy of social and economic programs for women, families, and children.

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Editor's Note

What is a feminist, particularly a Catholic feminist? What role does feminism play in the reproductive rights debate? This issue of *Conscience* offers several answers to those questions.

Mary Hunt critiques "feminists for life," the type of feminist celebrated by Catholic bishops and Helen Alvaré, their spokeswoman on abortion. In addition to examining the antichoice movement's use of the concept of feminism "for life," Hunt recommends several criteria for an adequate approach to feminism in the 1990s. Illustrating many of the distinctions drawn by Hunt is a sidebar with excerpts of a debate between Alvaré and Frances Kissling, president of Catholics for a Free Choice. We also look at an advertisement published by Feminists for Life—the organization—and at the views of New York's Cardinal John O'Connor on radical feminism.

We focus on two CFFC feminists, with a Spotlight on grassroots coordinator Jane Reilly and an interview with board member Angela Bonavoglia. Bonavoglia also contributes a review of German theologian Uta Ranke-Heinemann's *Eunuchs for the Kingdom of Heaven*, a book that does much to validate Catholic feminists. Finally, we review Marlene Fried's timely, provocative anthology, *From Abortion to Reproductive Freedom*, which advocates transforming the movement into a broader feminist struggle.

One recurring theme is the degree to which reproductive rights are linked with other human life issues. That is also the question CFFC asked and answered in our newly released analysis of the voting records of members of Congress. In "Actions Speak Louder," CFFC found that members who vote to restrict abortion rights are the same ones, by and large, who vote against legislation that would make abortion less necessary. Conversely, those members who vote prochoice on abortion generally vote to create social and economic conditions that welcome childbearing and support child-rearing. Most of the report appears as a special supplement, between pages 12 and 13.*

Some politicians, from Capitol Hill to the Archdiocese of New York, apply the term "radical"—as in radical feminism—as though it were a dirty word. This *Conscience* disagrees; "radical" refers to unearthing and examining the roots of beliefs and laws and working to transform those that grow out of sexist assumptions. We offer this issue on feminism in support of radical thinking.

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* *Copies of the full report are available from CFFC for $2 apiece or at bulk rates. Contact CFFC for more information.*

Packaging Feminism, *from page 1*

change our image, perhaps hire an Hispanic bishop as our spokesperson, and make our feminist case since feminism is so acceptable as to need mere qualification, not rejection. They might have instructed us to debate the bishops' spokesperson—something Frances Kissling did with the NCCB's Helen Alvaré at Boston College lately—and they might have given us tips on how to handle the opposition in the public forum. My guess is that Hill and Knowlton would have told us to market our position as "The natural choice is choice," rather than "The natural choice is life," their slogan for the bishops.

In lieu of advice from Hill and Knowlton—and in the belief that millions in public relations fees could be better spent on support for poor women—I offer the following analysis of feminism in the current public discussion of reproductive choice. I begin with some observations about the Kissling-Alvaré debate, offer a brief critique of the concept "feminists for life," and conclude with concrete suggestions for activists who enter the fray, countering in the public arena language and ideas that sound like ours but which are finally quite different.

Lessons of the Debate

The most impressive feature of the debate, staged by a group at Boston College, was Frances Kissling's respect for her opponent despite the fact that the debate format is inappropriate to our goal of dialogue and discussion. I cannot overemphasize, from my own many mistakes on this score, the importance of graciousness and respect for one's opponent. This disarms even the audience and will stand us in good stead for years to come. I applaud Frances Kissling for this and encourage her to continue modeling it.

Frances referred to Helen Alvaré as "prolife" throughout the debate, even though she does not find (nor do I) that phrase the most adequate one to describe the position being articulated. Helen does. But little is lost allowing people to be called what they want to be called, and much is lost objectifying and insulting persons who, we can reasonably assume, are acting in good faith. This does not indicate a need to back off of a critical look at what terms mean, and whether it makes sense to use a given term, but it is good practice to know what issues to disagree on and what issues to leave alone.

We learned a great deal from the debate about the strategy of the bishops and "feminists for life." We learned that referring to Catholics for a Free Choice as "Miss Kissling's organization" is a tactic designed to personalize, objectify, and trivialize the organization. It is a method taken straight from the briefing book of the Republican Party, which makes persons—including most recently Saddam Hussein—into the enemy, rather than dealing with the reality, however distasteful, of an organization, a staff, and a constituency.

We heard constant reference to the caricature of most prochoice Catholics' position as "abortion during nine months for any reason," rather than the much more nuanced position many of us hold. Our demonstrated concern for fetal life, even if our conclusion is not the same as theirs, is passed over, and the welfare of the pregnant woman is nowhere in evidence.

> "Feminists for Life" is a curious redundancy. Who might feminists for death, feminists against life, be?

We were flattered by the heavy reliance on our materials, especially *Conscience*, and on feminist prochoice writers like Rosemary Radford Ruether, Adrienne Rich and Carol Gilligan. However, much of their work was quoted far afield of their contexts and with no apparent concern for the fact that they were being quoted against their own positions. It was reminiscent of my high school and college debate days when people would come armed with index card containers as long as their arms, empty, or with scrawled quotes of people whose names they could barely pronounce. It is a debate technique but not the stuff of serious engagement. Deep analysis of issues just isn't there.

Debate is the preferred mode of the bishops, a likely choice since debate is based on a patriarchal model. The goal of a debate is to win; the secondary result is to maintain power. A feminist goal is to resolve differences, even

(See Packaging Feminism, *page 6)*

"Two Kinds of Feminism"

Excerpts of a Catholic Debate on Abortion and Feminism

Feminists who disagree about abortion probably also differ about feminism. Some of those differences were brought out in the April 11 debate at Boston College between Frances Kissling, president of Catholics for a Free Choice, and Helen Alvaré, Director of Planning and Information for the Prolife Secretariat of the National Conference of Catholic Bishops.

Alvaré: Using abortion as a means of solving the complex variety of problems women suffer—has it served women's dignity? Or has its very use really undermined feminist ideals?

Take a look at what has happened to the situation of women since *Roe*. . . .We have 13 percent more women falling into poverty since *Roe v. Wade*; 25 percent more women without health insurance. . . .The divorce rate has increased. When women divorce, their rate of earnings goes down 30 percent; men's goes up 40 percent. From a feminist perspective, are women any closer to achieving a society that behaves in accord with feminist ideals?

I have to separate out two kinds of feminism. . . .There is one kind that is called celebrational or cultural feminism, which acknowledges differences between the sexes, but not any inferiority in those differences. It acknowledges women's powerlessness, but hopes to bring about a change in that inequality by taking advantage of women's unique gifts. Another feminism—radical feminism—sees women's reproductive capabilities as a liability. It sees sex as a battleground where men oppress women.

So what are some of the tenets of celebrational feminism, and are they being carried out with an abortion culture?

Well first of all, a celebrational feminist principal is nonviolence. Abortion is violent. . . . If I stood in front of you and performed on a cat what happens to an unborn human life in an abortion, you would know in your heart and your mind that that was a violent act.

Another feminist principle is relationality: that women relate to others in an interdependent mode, not in what they consider the male mode—the dominant person and those who are dominated. . . .

But abortion severs relationships, not only with that unborn human life, but with all the persons around you who are deprived of consulting, who are deprived of a person.

No person is an island. This is a feminist principle, yet abortion says, "No, the woman is absolutely autonomous." There is no relationship with an unborn human life. Rather, it is nothing more than a part of her body.

> A violation of celebrational feminist principles leads to a denigrating of what women do; that is, they can become pregnant, they can nurture, they can raise these children.
>
> —Helen Alvaré

Another feminist principle is respect for others' freedom. But when we deny the freedom [and] rights of an unborn human life, we are acting antithetically to that.

Feminists have an option for the oppressed. . . .And yet a mentality that wants legal, unrestricted abortion and that doesn't discuss—let alone recognize—the value of the life on the other side is not one that has an option for the oppressed. Instead, it wants to build up women's freedom on the backs of those who have been so recently oppressed.

And what does a violation of these principles lead to? Abortion as a substitute for a real family policy. A denigrating of what women do; that is, they can become pregnant, they can nurture, they can raise these children. This has always been denigrated, now even more so. . . .

It leads to the adoption of the male values that have been so roundly and so fully criticized by those who support legal abortion for nine months.

A question I have is, when you talk about women as the . . . primary question, [whether] feminism is just a mechanism to assure that women's desires or wishes get fulfilled. How is

that any different from a masculine system that says, "However the system operates, it operates so I am on top"?

Kissling: Feminism is about women. It is not about characteristics of women, whether we are nurturing, whether we are better than men, whether we are good, ... docile, aggressive—those are human characteristics. That is not what defines me as a feminist.... Feminism is about women being for women.

Feminists are not necessarily pacifists.... We have to be careful to define what our movement is about, and not to allow ... the cooptation of feminism by a whole variety of [laudable] movements that are not necessarily feminist.

Feminism for me is a primary commitment... to women's well-being. It is a commitment to analyze history, politics, life, and behavior by asking the question, "What does this mean for women? What will this do to women and their well-being?" There can be disagreements about what it will do, but that will be the primary question.

Feminism is also a corrective, and in that sense there is a bias in feminist thinking. We are attempting to [correct]...years of discrimination and oppression of women. We are going to put in the front of our minds the needs of women. That is what we must do.

> A feminist position on abortion will be radical. It is about change.
>
> —Frances Kissling

A feminist position on abortion...will be radical. It is about change.... Everything is up for grabs, including dogma. We need to...ask ourselves the most basic questions about nature, about natural law, about who we are, and about why things are or are not.

A feminist position on abortion will place abortion in a larger question, which will be, "What am I to do about the procreative power that is mine by virtue of the fact that I have been born female?"

It will be woman-centered. The question will be about what women are to do, not about who the fetus is. This is not to say that the question of who the fetus is is unimportant, but rather that it is not the primary question.

The feminist position will take our reasons for abortion seriously....We have been told that most women have abortions for soft reasons....I'm sorry—21 percent of women say they have abortions because they are not ready for responsibility. Is that not serious? Or because the woman is concerned about how having a baby will change her life. Is that not serious and deserving of our attention as women who care about women?

A feminist position on abortion will have respect for life, but it will define life as beyond individualistic life. As a Christian who believes... in values greater than life itself,... I believe that respect for life means more than respect for individual life. It means respect for the life of our families, for the life of our children, for the life of our planet, for the life of our community.

A feminist position on abortion will be wary of the possibility that women will be used as instruments, as the means to an end....

Feminists for Life have claimed that abortion lets men off the hook, it lets society of the hook, and that therefore abortion should be banned. Well the reality is that, first of all, men are off the hook. They are off the hook whether it is abortion, childbearing, child rearing, wife support, battering, you name it. Banning abortion is not the means to get them back on the hook. In addition, banning abortion uses women as a means to an end, and that is not the way to do it.

A feminist position will include the reality that we do not have all the answers and that perhaps there is not one answer. Abortion is not a solution to social problems. The solutions to social problems lie in much broader work.

Packaging Feminism, *from page 3*

agreeing to disagree rather than to change each other's minds; a secondary result is that the power equation changes, with power being shared. No wonder the bishops prefer to debate. Our challenge is to engage in gracious, respectful conversation while offering persuasive analysis when others involved prefer to debate. Format is all.

"What Kind of Feminist Are You?"

"Feminists for Life" is a curious redundancy. Who might feminists for death, feminists against life, be? These certainly do not describe those who favor legal, safe, economical abortion.

To unravel this conundrum I try to understand what "feminist" might mean.

I learned from Brazilian feminists not to ask, "Are you a feminist?" since that can end certain conversations. Rather, I learned to ask, "What kind of feminist are you?" Of course such generosity opens the door to the kind of loose use of the term in the title "Feminists for Life." Still, I am convinced that it is better to have this kind of discussion than to say that people who oppose abortion are not feminist.

> Feminism is not about women replacing men, female thinking replacing male. It is an active search for justice for all.

Feminists for life, if Helen Alvaré is a good example, make certain distinctions between and among feminists that bear investigation. They juxtapose "celebrational" or "cultural" feminists, and "radical" feminists. This distinction is at best uncommon in the scholarly literature on the history of feminism. It seems to exist only in the minds of those who would instrumentalize feminism to divide and conquer women. Not so coincidentally, the same dichotomy appears under another guise in the second draft of the bishops' pastoral letter on women, wherein the distinction is made between Christian feminists and other, presumably radical, feminists. The latter are defined as those who advocate "such aberrations as goddess worship, witchcraft, liberation from conformity to the sexual morality taught by the church or acceptance of abortion as a legitimate choice for women under pressure." (Par. 132, *One in Christ Jesus*).

This is a variation on the good feminist versus bad feminists approach. It is an old trick, but it gives away the fact that feminism, once considered a dirty word in church circles, is now an accepted fact. The only thing to do is to circumscribe it, make it acceptable by qualifying it ad absurdum. Such an approach is a far cry from the previous rejection of feminism in church circles and should certainly be seen as evidence of our inroads.

If such groups persist in using the term feminist, however, some minimal definition of the word is in order. While it is important to grant wide latitude for the sake of discussion, it is neither necessary nor prudent to proceed as if even the most far-flung concepts adequately defined feminism in 1991. What, then, is feminism, and what is it not?

I find Feminists for Life's own materials helpful to illustrate certain common misconceptions about contemporary feminism. Its pamphlet "Abortion Does *Not* Liberate Women" (undated), with the main section entitled "Feminism is part of a larger philosophy that values all life," presents tautologies and non sequiturs that beg questions central to most current feminist thought.

Feminism as explained in this pamphlet rejects "the male worldview," "a man's world," and "male thought patterns." While this may sound to the uninitiated like feminism, it is not, in my judgment, feminism that is adequate and meaningful in the 1990s, given the evolution in feminist thinking during the past decades. Rather, it is a one-dimensional, antimale approach that may sound like the rhetoric of early feminism but that has long ago been replaced by a complex interplay of socio-economic and political factors.

Feminism is not about women replacing men, female thinking replacing male. It is an active search for justice for all. It is a commitment to correct the primary power imbalances in which, for example, many African-American men have less power than some white women. It is the hard work necessary to create a context in which real choices obtain for all.

I find it shocking and disingenuous for Feminists for Life and certain antichoice bishops to subscribe to a one-dimensional outdated

feminism when it suits their anti-abortion purposes. They would be the first ones to cry foul at any hint of female superiority in church or society.

The Feminists for Life pamphlet does not tell us what is the "larger philosophy that values all life" and that encompasses feminism, nor are we privy to why abortion as a woman's right would contradict it. Rather, feminists are identified with a goal I consider specious: "They strive. . .to create a world that recognizes the moral superiority of maternal thinking and is, therefore, gentle, loving, nurturing, and prolife."

First, however, feminism does not grant any special claim to "maternal thinking," whatever that may be, nor does it grant special claims to mothers.

Second, would that all feminists were "gentle, loving, nurturing." It simply is not the case, and romanticizing feminists is naive at best. Those who are not feminists are not necessarily tough, unloving, lacking in nurture, either. The point is that such stereotypic thinking went the way of hoopskirts years ago in feminist circles. Human characteristics of human beings, not behavior conferred by gender, is what feminist thinking promotes.

Third, the assertion of a "prolife" conclusion to such muddled thinking does not follow logically or morally. Rather, it is asserted along with the rest in a kind of conceptual con game, leading to a linguistic impasse and some intellectual paralysis.

What gives away the real agenda in all of this is that nowhere in the preoccupation with fetal life (a.k.a. "children" in this pamphlet) does the well-being of female life—women—enter the picture. Feminism without women is not feminism. The material conditions of real women's lives—especially the reality of violence, poverty, racism, and inadequate resources for young and poor women—and a commitment to improve those conditions are the starting points of a feminist analysis, especially a religious feminist approach. One may not wish to put women first, but not to and then to use the label "feminist" raises very serious questions of credibility and understanding.

What then would be an adequate approach to feminism? Feminism in the 1990s is an analysis of unjust power relationships and structures, and the practice of justice-seeking strategies to right those; it takes women's well-

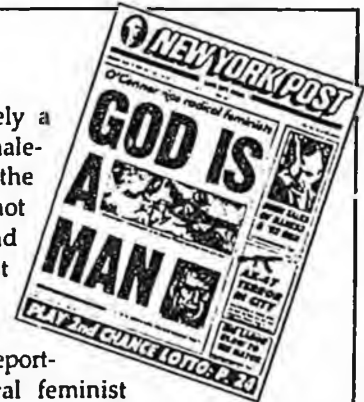
(*See* **Packaging Feminism**, *page 9*)

Is God a "He"?

Cardinal John O'Connor disputes the presentation of his Father's Day sermon in the *New York Post*, and the *Post* stands by its page-one headline: "GOD IS A MAN. O'Connor rips radical feminists."

Not in dispute is the gist of the New York archbishop's sermon, which seems to pit "good" feminists against "bad" feminists. "Radical feminism [is] sad indeed. It makes it particularly difficult for women in the Church who want to assume rightful roles to be given a credible hearing," the cardinal said, according to both the *Post* and the doctrinaire Catholic *Wanderer*. "We have no right to reconstruct [Christianity] as we like or choose. We are not authorized to change Our Father into Our Mother." In a statement issued later, O'Connor's office said that, "although God must always be considered [the] Father as revealed in the Gospels, that does not mean God is a man," according to the *Wanderer*.

Frances Kissling, president of Catholics for a Free Choice, said O'Connor "trivialized" the the issue. "The use of male constructions to refer to God are largely a remnant of a male-centered view of the universe. We're not trying to pretend that Jesus Christ was a girl."



God's gender aside, O'Connor reportedly said "radical feminist theory" interferes with "valid feminism: . . .the struggle for equal rights, appropriate recognition, equal pay for equal work, the struggle to be treated with equal dignity." One might wonder what those concepts mean to O'Connor, a leader in an institutional hierarchy that staunchly denies women equal work.

Saying Christianity has "liberated" women, O'Connor cited a family from a polygamist culture in Africa: When the father became a Christian, he chose one of his wives. For the others, he arranged new marriages or returned them to their families with dowries.

If It Was Good Enough For Susan B. Anthony, It's Good Enough for Feminists for Life

"I deplore the horrible crime of child murder. . . . No matter what the motive, love of ease, or a desire to save from suffering the unborn innocent, the woman is awfully guilty who commits the deed . . . but oh! thrice guilty is he who drove her to the desperation which impelled her to the crime."

Susan B. Anthony, *The Revolution*, July 8, 1869

With such quotations, Feminists for Life of America (FFL) hopes to show that you can be fully-credentialed feminist and oppose legal abortion, too.

FFL, born in 1972 in reaction to the pro-choice position of the National Organization for Women (NOW), attracted attention last year with an advertisement that asks, "What did our Feminist Foremothers say about Abortion?" The ad answers that teaser by quoting Susan B. Anthony and four other nineteenth-century feminists who decried abortion, or at least sexist social conditions that have contributed to abortion.

Among the periodicals that published the ad were *The Utne Reader, The Progressive, Christian Century*, and *Daughters of Sarah*.

The ad ignited *The Utne Reader's* letters-to-the-editor page. In the next issue, one reader accused FFL of manipulating the suffragists' views. *Utne's* editors announced that they would not accept the ad again because, after some research, they believed FFL took quotes out of context.

For example, the quotation by which FFL represents Matilda Gage is this: "[This] subject. . .lies deeper down into woman's wrongs than any other. . . .The crime of abortion is not one in which the guilt lies solely or even chiefly with the woman. . . .I hesitate not to assert that most of this crime of 'child murder', 'abortion', 'infanticide', lies at the door of the male sex."

Faulting FFL's use of those lines, the magazine's editors marshalled this quotation from Gage: "Enforced motherhood is a crime against the body of the mother."

The dispute did not end there. In the following issue, readers continued to debate the position of the "feminist foremothers," as well as the propriety of the progressive magazine's acceptance of the ad.

For a taste of the sometimes piquant debate, try this query from Cynthia Bogard, editor of the New York State NOW's Action Report: "Would you take an ad from Jews for a Nazi America? How about from Black Panthers for a Klan-Controlled America?" Bogard said the ad demeaned notable women by quoting them "out of literary and historical context for the purpose of rescinding modern women's rights."

Utne also printed a response from Mary Krane Derr, who had culled the quotations in her research into early feminism. The comments may be "painful" reading for prochoice feminists, Derr wrote, but "the past cannot be undone; it can only be reckoned with."

FFL President Rachel MacNair also spoke up. "We never implied that 19th century feminists were 'anti-choice,' " MacNair wrote. "In their clear stand against 'enforced motherhood,' abortion was seen not as prevention, but as yet another result. Abortion and infanticide were problems to be solved by giving women greater rights."

The editors ended the volley in the November/December 1990 issue by saying they would reject ads that clash with the values of *The Utne Reader.*

Mother Jones tentatively accepted the FFL advertisement but rejected it upon requesting and receiving from FFL the full context of the essays from which the quotations were drawn, according to the FFL newsjournal, *Sisterlife*. FFL reports that *Mother Jones*, like *Utne*, cited the Gage passage against "enforced motherhood."

Recounted by Maggie Hume, editor of Conscience.

Packaging Feminism, *from page 7*

being as the primary lens of analysis and praxis of liberation. A feminist analysis and strategy includes concrete attention not only to gender but also to class, race, sexual preference, nationality, social context, and physical capacity; it gives priority or a preferential option to women who historically have been marginalized because of their particular place within each and every one of those categories.

Feminism in the 1990s is incomplete and inadequate if it does not include the invaluable insights of womanist thinkers and activists such as Katie Geneva Cannon, Jacquelyn Grant, and Cheryl Gilkes, to name just a few in the field of religion. They use Alice Walker's term "womanist," in contrast with feminist, to indicate a model based on the survival of women and their dependent children, not a liberal rights model. While those of us who are white are urged not to take on "womanist" as our label because it does not emerge from the particularity of our experience, we are well advised to make use of the analysis, to express our indebtedness to our sisters from racial-ethnic groups other than our own, and especially to bring their socioeconomic insights to bear on our analysis and strategies.

In this feminist, womanist context, fetal life is not unimportant. But female life is central, and therein lies the challenge to feminists against legal abortion to make their case, a case that remains to be made. Far from suggesting that a feminist must be prochoice, I am suggesting that we who are prochoice feminists need not back off of critical thinking or commonly agreed upon criteria for feminism. We need not shrink from showing the fallacy and the antiwoman nature of a feminism which does not grant woman reproductive choice. These arguments should not be left aside in the name of civility. In fact, civility is served much better when we name the contradictions, albeit politely, and get on with the discussion.

Into the Fray

I hope that prochoice feminists will continue to engage in polite, respectful discussion with feminists who take a contrary position. Such exchange is essential to social change since people with whom we disagree have valuable things to teach us about our own positions as well as about theirs. In that spirit, I make the following suggestions:

1. Let us follow Ms. Kissling's example of graciousness in her debate with Helen Alvaré. It is important to keep the conversation going for mutual learning. Ironically, those with whom we disagree often do better than we ever could at showing the weakness of their own positions

2. Let us avoid the debate format since it is set up to produce winners and losers and maintain the status quo. Instead, we can invite those with whom we disagree to round-table discussions where several people from differing positions come together to talk. This is not easy and requires lots of preparation and follow-up. But it holds the possibility of a much richer discussion than the forced, flat format of a debate. It involves more people in serious, sustained work, not simply glitzy, one-shot deals that are more like gladiatorial matches than policy discussions.

3. Let us keep in front of us that feminism is about justice. A feminist approach to the question of abortion is about women and fetuses, not women or fetuses. It is not women's well-being in opposition to fetal life, but the complex web of relationships that includes both woman and fetus and myriad other factors. The bottom line of feminism is justice, and women and fetuses have quite different claims in that regard.

> Feminism without women is not feminism.

4. Let us read and study feminist theory and theology to deepen our understanding of historical and contemporary issues. Some of these include violence, imbalance of power, the marginalization and exclusion of persons and groups (usually women), and efforts at inclusivity and mutuality. Remarkable analysis is emerging from feminist theorists in the United States and abroad that can shed light on these issues and be translated into just public policy.

Beverly Harrison named the ethical crux of reproductive choice issues insightfully—"women as moral agents" with "the right to bodily integrity." A shorthand form for that feminist principle is choice. I presume that even Hill and Knowlton knows that. Maybe the P.R. people will teach the bishops, for a fee.

Mary E. Hunt, a feminist theologian, is cofounder and codirector of the Women's Alliance for Theology, Ethics and Ritual. Hunt serves on the board of directors of Catholics for a Free Choice. Her most recent book is Fierce Tenderness. *This essay is an adaptation of a May 3 speech at CFFC's training conference for grassroots leaders.*

"It's My Choice"

HIGHLIGHTS

The issue of abortion is an issue of necessary choices . . . individual choices, made by people from all walks of life

The Facts . . .

- One woman dies every three minutes from complications from ILLEGAL abortion somewhere in the world.
- In the United States, abortion-related deaths decreased 92% since the Centers for Disease Control began surveillance in 1972.
- The majority of women who have had an abortion were using a contraceptive during the month they conceived, and so were actively trying to avoid pregnancy.
- The majority of women having an abortion have had no previous abortions; and most (84%) have had none or one.
- Most abortions (91%) are performed in the first 12 weeks, and nearly all (99%) are performed by 20 weeks or less, well before the fetus becomes viable.

The History . . .

Throughout history, women have had abortions. Abortion has been legal at various points in American and World History. Legal or illegal, abortion is *not* a new phenomenon.

The Reasons . . .

Health.

[1] **Women's lives are being saved.**

Abortion-related deaths for American women dropped by more than 40% in the *single year* following legalization of abortion. (12,13)

[2] ***Licensed medical personnel,* trained in the safest abortion techniques, perform all legal abortions.**

Social Welfare.

[58] **In 1985, *1,031,000* American teenagers became pregnant; of those, 31,000 were younger than age 15.** (31)

Abuse.

[69] **2.1 Million Children were victims of child abuse or neglect in 1986.**

This is a startling 32.8 child-victims for every 1,000 U.S. children. (20)

Legal Implications.

[89] **THE RIGHT TO PRIVACY IS THREATENED. The outlawing of abortion is an extreme example of invasion of privacy.**

It means compulsory pregnancy for women, regardless of individual beliefs and circumstances.

Majority Opinion.

[96] **American voters consistently state that they favor keeping abortion legal, with 56% of those polled saying that they support "keeping it legal for women to be able to have abortions when they decide to have one."**

In fact, *88%* of those polled believe that abortion should be an available option under at least certain conditions. (25)

"It's My Choice"

101 Reasons Why Abortion Must Be Legal

ABORTION.

It is an issue of necessary choices. Women's lives and health. Children bearing children. Extreme birth defects. The trauma of rape or incest. Severe economic disadvantage. Hard issues. Hard choices. Personal choices. Armed with facts, every woman must be able to say . . .

"IT'S MY CHOICE!"

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2nd Edition 1991

The Facts.

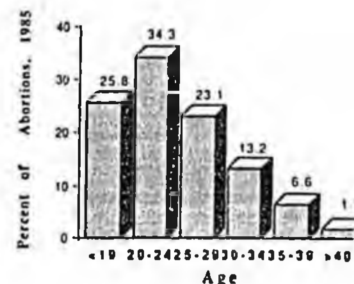
The Statistics of Abortion in America.

- Each year nearly 3 out of every 100 American women aged 15 - 44 have an abortion. (1)
- In 1985, there were 1.6 million abortions performed in the United States. (1)
- For every 1,000 live births in the U.S. in 1985 there were 422.4 abortions. (1)

Women from all walks of life, all ages, races, and life situations, have made the choice to have an abortion.

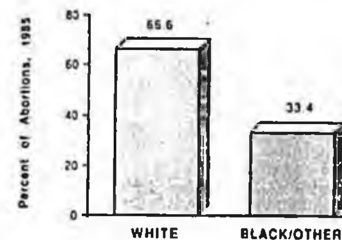
Age

In 1985, women between 15-29 years of age had 80% of all abortions. Teenagers accounted for 26% of all abortions. (2)



Race

In 1985, two-thirds of the women having abortions were white, one-third were black and other minority women. (2)

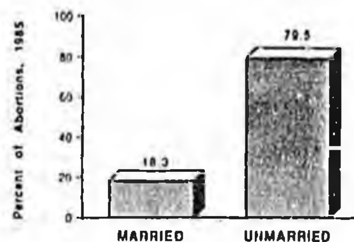


In the four years following legalization of abortion (1972 to 1976), among women having an abortion, the percentage of black and other minority women increased from 23% to 33%. (1) Thus, legalization quickly improved access to safe, legal abortion services among minority women.

Among women having an abortion, the proportion of black and other minority women under age 15 is more than *twice* that of white women. (2)

Marital Status

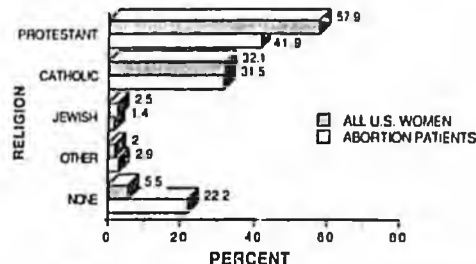
Unmarried women had 1,174 abortions for every 1,000 live births in 1985; married women had 93 abortions for every 1,000 live births. Among women having abortions, the proportion of unmarried women increased steadily from 70% to 80% between 1972 and 1985. (2)



Religion

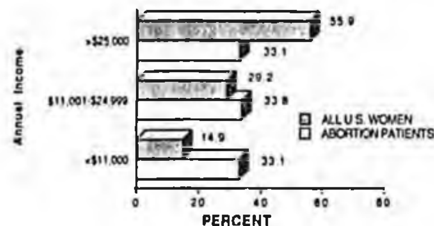
The religious affiliations of women who have abortions closely follow those of the U.S. female population in general. Because there are more Protestants in the US population, women who identify themselves as Protestant account for a higher percentage of the abortions performed in the U.S. than any other religious group.

However, when comparing within religious groups (for example, percent of Catholics having abortions compared to the percent of Catholics in the U.S. population), Catholics have proportionally more abortions (30% more) than Protestants. (3)



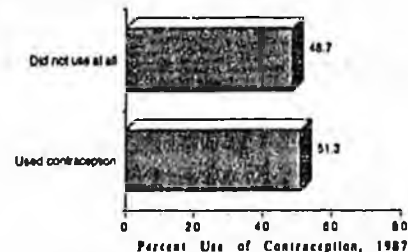
Income

As a proportion of the U.S. population, women in low income families (annual income of $11,000 or less) were more likely to have an abortion in 1987 than wealthier American women. (3)



Contraceptive Use

More than half of abortion patients surveyed were using a contraceptive *during the month in which they conceived.* (3)



It is evident, then, that the majority of abortion patients surveyed were actively attempting to avoid pregnancy.

It is also important to note that the majority of women having an abortion (57%) had no previous abortions, and most (84%) had one or none. (2)

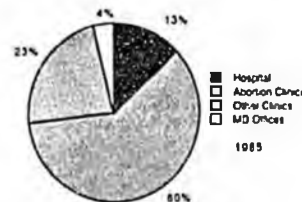
When Abortions Are Performed

Fifty-one percent of the 1.6 million abortions performed each year take place at *8 weeks gestation or less.* Ninety-one percent of all abortions are performed within *the first 12 weeks* of pregnancy, when it is safest for the woman. Ninety-nine percent are performed at 20 or fewer weeks. (1)

Percent of Abortions Performed At Four Stages of Gestation

Where Abortions Are Performed

When abortion was first legalized nationally in 1973, most abortions took place in the hospital. Now, however, the highest percentage of abortions take place outside the hospital, where costs are less and services are more specialized. (4)



Percent of Abortions Performed By Provider

Hospitals are still important in making abortion services available. Women with a history of medical problems, and women having instillation abortions, must be hospitalized. In addition, in many U.S. counties the hospital is the only facility where an abortion can be obtained.

A Glimpse of Abortion and Health Throughout the World

One woman dies every three minutes from complications of illegal abortion somewhere in the world.(1)

There were 55-60 million abortions worldwide in 1988—half legal, half illegal. (1)

- In developing countries, illegal abortion is a leading cause of death among women of reproductive age, killing an estimated 100,000 women each year. (4)
- In Latin America, illegal abortion is the number one killer among women aged 15 to 39. (5)
- In Brazil, where abortion is illegal, more than three million illegal abortions take place each year. Four million live births occur each year. (4)
- Bangladesh has an estimated 7,800 deaths each year attributable to complications from illegal abortion. (1)
- In Kenyatta National Hospital, Nairobi, 50 women are admitted DAILY for complications from illegal abortion. (5)

Cost, availability, and abortion rates vary in developed countries. There is no charge for abortion services in Sweden, Great Britain, and France; costs are very low but paid by the woman herself in the Netherlands and Canada. Services are most easily accessible in the Netherlands and Sweden. (1) It is interesting to note that the countries with the LOWEST abortion rates have the BEST accessibility to abortion and birth control services, and sexuality education programs.

Changes in abortion laws have had dramatic effects on abortion-related deaths and complications.

- In Czechoslovakia, abortion-related deaths fell 56 percent between 1953 and 1957, after many restrictions on abortion were lifted. (6,7)
- In Hungary, abortion-related deaths fell 38 percent between 1958 and 1962, after restrictions were lifted. (6,7)
- In Romania, abortion-related deaths increased 700 percent following passage of laws restricting legal abortion in 1966. (6,7)

And . . .

- In the United States, the number of deaths associated with abortion fell considerably following legalization, with a 92 percent decrease in deaths since the Center for Disease Control began surveillance of abortion in 1972. (2)

> **Bucarest, Romania.**
> Associated Press, January 3, 1990
>
> Wailing infants compete for the attention of a single matron. Toddlers stand in their cribs rocking from foot to foot. Eight-hundred orphaned or abandoned children in Orphanage No. 1 . . . Nicolae and Elena Ceausescu's youngest victims.
>
> The laws prohibited birth control, abortions and family planning information for women with fewer than *five* children.
>
> "The unhealthy and abandoned children living in this facility are a direct result of national policy," said Dr. Margareta Creteanu, the orphanage's chief medical officer. "An ill woman could not have an abortion, so many genetic illnesses were passed to the children."

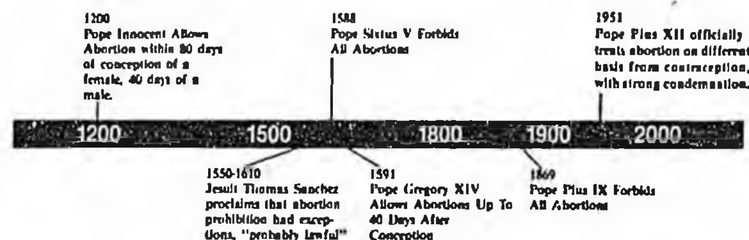
Ban Abortion. Limit Birth Control. Freeze Adoptions. Where does it end?

The History.

Throughout history, women have had abortions. Legal or illegal, abortion is not a new phenomenon. (9)

Laws against abortion did not, DO NOT, stop women from having abortions. There is no question that there will be abortions. The only question is whether women will be injured, or maimed . . . or die.

And it is interesting to note that in Christian Religions (9,10) . . .



In Judaism . . .

The Mishna, the first post-Biblical compilation of Jewish law and tradition of the third century, claims the legality of abortion in the words "her life takes precedence over its (the fetus) life." Thus "Just as she is permitted to sacrifice a portion of her body for her greater good, so, too, may she obtain permission for an abortion in order to assure her overall well-being." (11)

*"Quickening", the first motion of the fetus felt by a pregnant woman, usually occurs in the second trimester, 18-20 weeks after conception.

The Choices.

Parenthood . . . Adoption . . . Abortion.

Individual Lives.
Individual Choices.

Private.
Urgent.
And Personal.

Each choice carries the burden of responsible, informed decision-making, based on individual life situations.

Abortion is one choice that must be legal.

Because motherhood cannot be forced, nor legislated.

The Reasons.

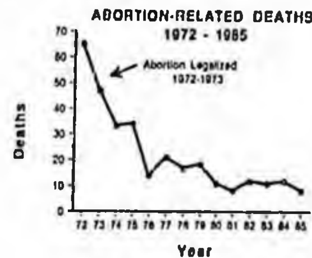
Upholding the Freedom of Choice . . . The Freedom to Choose One's Destiny.

ABORTION IS NEVER AN EASY DECISION. For this most personal choice, women and men have fought for, and achieved, women's legal rights to make their own decisions. Here are many of the important reasons why abortion must be legal.

The Nation's Health

1 Women's lives are being saved.

Abortion-related deaths for American women dropped by more than 40% in the single year following legalization of abortion. (2,12,13)



2 Women's health is being saved.

Before 1973, many women had very serious complications from illegal abortions. An average of 18 women per day were admitted to New York City hospitals for treatment of incomplete abortion prior to legalization in New York. (12)

3 More healthy babies are being born.

Couples at risk of having children affected with severe and often fatal genetic disorders have been willing to conceive because of the availability of amniocentesis and safe, legal abortion. (14)

4 Fewer babies are dying from severe, traumatic birth defects.

Women and families are no longer forced to carry a severely affected fetus to term, only to have to face the tragic suffering and death. (12)

5 American women can have children that they can care for adequately.

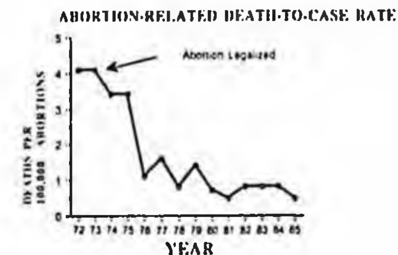
Crippling emotional and financial hardship is relieved.

6 Teenagers are better able to postpone childbearing.

Although teenage pregnancy remains a problem of national concern, the legalization of abortion has meant increased alternatives and lifetime opportunities for the teen faced with an unplanned pregnancy. Teenagers who bear children face enormous risks: health problems, school dropout, high divorce rates, poverty, and emotional turmoil are but a few.

Changes in Abortion Since Legalization.

7 Legalization of abortion has saved women's lives. Since the Centers for Disease Control began surveillance of abortion in 1972, 93% fewer deaths have occurred. (2,13)



8 **Since abortion was legalized nationally in 1973, it has become a medically safe alternative, improving the lives of America's women.**

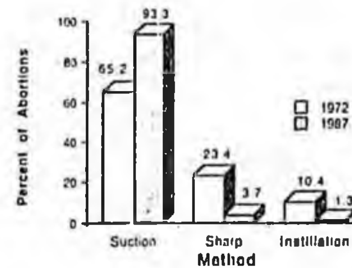
Before legalization, many women were reproductively crippled and emotionally scarred from illegal abortions.

9 ***Licensed medical personnel,*** **trained in the safest abortion techniques, perform all legal abortions.**

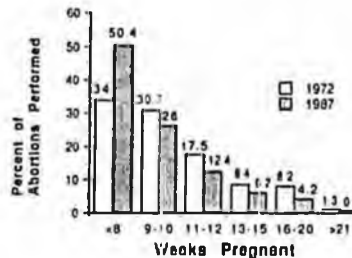
Before legalization, abortion services were not regulated . . . they were performed in back alleys, on kitchen tables, by people preying on desperate women.

10 **The safest medical procedure for performing abortion is now the most frequently used procedure.**

Suction curettage is now used in 93% of all abortions, and is *twice as safe* as sharp curettage, a procedure used extensively before legalization. Between 1972 and 1987, the use of suction curettage increased in use by 28%. (2)



11 **Access to legal abortion has greatly reduced delays in obtaining abortion services, so that abortions are performed earlier and are safer.** (2)



12 **Today, most abortions are performed in outpatient abortion clinics, staffed with well-trained, skilled personnel.**

Nearly all clinics have counselors on staff, who talk with women about all options available to them, and explain all risks and benefits of abortion.

13 **Most abortions performed in clinics now cost around $230. Before legalization, abortions were likely to cost $500 or more.** (15)

Even figured at a conservative 5% inflation rate per year, that amounts to a pre-legalization cost of almost $1,000.

14 **Today's abortion procedure, performed at 12 weeks of pregnancy or before, takes 10 minutes or less and causes minimal discomfort.**

The Safety of Abortion.

15 **The death rate from legal abortion at all stages of pregnancy is very low.** (14)

	Risk of death
Abortion, all stages	.7 per 100,000 abortions
Tonsillectomy	1.4 per 100,000 procedures
Childbirth	12.0 per 100,000 live births

16 ***Fewer than 1 percent*** **of women who undergo legal abortion sustain a serious complication.** (14)

17 **After 20 weeks of pregnancy, the risks of abortion are comparable to the risks of childbirth. The risks of abortion related complications increase with every week the procedure is delayed past the 8th week.** (1,14)

18 **An early abortion, performed by suction curettage, presents no problems in regard to later childbearing.** (1)

The Physical Health of the Pregnant Woman.

19 **A woman with uncontrolled diabetes faces extreme physical risk in pregnancy.**

20 **A woman may have cancer, diagnosed during pregnancy, and be in need of treatment detrimental to the fetus.**

21 **A woman may have a severe heart condition, making a pregnancy dangerous or life threatening.**

22 **Pulmonary hypertension may make pregnancy a fatal mistake.**

23 **An accident may threaten the life of the pregnant woman.**

Car accident, plane crash, crime and violence . . . all may cause extreme physical trauma. Pregnancy is an added physical burden to a life already in danger.

24 **The woman with AIDS faces increased risk of deadly disease during pregnancy.**

The immune system is depressed during pregnancy, and several viral diseases appear to be more common and virulent. The additive effects of pregnancy and HIV infection on the immune system can be devastating. (18)

25 **Drug dependence is a physical, emotional, and economic disaster, most especially during pregnancy.**

26 **Alcoholism, like drug dependence, dramatically increases the medical, emotional, and economic risks for a pregnant woman.**

27 **A stroke or aneurism during pregnancy can cause coma and/or brain death in a pregnant woman, making pregnancy a life threatening condition.**

28 **Kidney disease can cause extremely high risk medical problems in pregnancy.**

29 **An older woman faces increased medical risks during pregnancy, yet is still at risk for unintended pregnancy.**

30 **A woman may be medically unable to use effective birth control methods, putting her at high risk of a traumatic unintended pregnancy.**

For a variety of reasons, including heart conditions, hypertension, mental dysfunction, effective birth control methods may not be an option for a woman.

31 **Even when used conscientiously, birth control methods do fail.**

New data indicate that birth control failure rates during the first 12 months of use are: (17)

Method	Rate
Oral contraceptives	6.2
Condoms	14.2
Diaphragm	15.6
Rhythm	16.2
Spermicides	26.3

32 **A woman may be strongly advised by her doctor not to get pregnant, due to illness or hereditary factors.**

Until birth control is 100% effective, abortion must remain an option.

The Physical Health of the Fetus.

33 **Thirteen percent of women having abortions have been advised that their fetus has a defect *or* they fear that the fetus has been harmed by medications or other conditions.** (1)

34 **Technology now allows women the opportunity to make informed choices when faced with the certainty of serious fetal problems.**

Ultrasound viewing and amniocentesis, an examination of the fluid surrounding the fetus, can now detect serious birth defects.

35 **Physician administered medicines, administered before detection of pregnancy, can cause severe deformities.**

Case in point: thalidomide. Abortion must be a legal option.

36 **Drug dependence in pregnant women can have devastating physical effects on the fetus.**

A woman must be able to choose abortion *or* parenthood.

37 **Alcoholism in pregnant women can have profound effects on the fetus.**

The effects include severe fetal alcohol syndrome, with physical and mental trauma, as well as emotional, psychological and economic failure of the families involved. These effects do not end at birth. Abortion must be an option.

38 **Exposure to chemicals, medications and radiation can cause birth defects, ranging from the simple to the severe.**

Unknowing exposure before pregnancy is detected can be life altering, and abortion must be one alternative.

39 **Hereditary disease and genetic disorders can have devastating, life altering effects.**

Parenting a special child must be an option, not a forced decision.

40 **A pregnant woman with AIDS, a fatal disease, faces the devastating possibility of a child born with AIDS.**

The frequency of transmission from infected mothers to their infants is as high as 50%. And a child born to a woman with AIDS will soon lose its mother. Women must have alternatives available for tragic situations. (18)

41 **Many contagious diseases strike pregnant women with severe consequences.**

Many fairly common and non-threatening diseases can cause severe problems in pregnancy, such as major birth defects.

42 **Use of fertility drugs can produce as many as 9 embryos.**

If all are allowed to develop, none will survive.

43 **An older woman who becomes pregnant is at increased risk for having a child with birth defects.**

The Psychological Health of the Woman

44 **A pregnant woman who is mentally retarded may be unable to adequately care for a child.**

Pregnancy and childbirth may create unmanageable emotional stress for such a woman.

45 **A major psychological disease, such as schizophrenia or manic depressive illness, may cause a woman to be incapable of caring for a child.**

46 **A woman who is suicidal may be unable to withstand a pregnancy.**

47 **Unintended pregnancy can cause extreme and debilitating psychological stress.**

Such stress may show itself in depression, alcohol and drug abuse, and even child abuse following the birth of an unwanted child.

Sexual Assault and Abuse

48 ***Sixteen thousand women* become pregnant as a result of rape or incest each year and subsequently have abortions.** (1)

Rape

49 **Rape can happen to anyone. Young, old, black, white, rich, poor. Anyone.**

It is estimated that one out of every ten American women will be raped in her lifetime. Pregnancy is but one traumatic consequence.

50 **Rape is very under-reported; somewhere between 1-in-5 to 1-in-20 rapes are reported to authorities.** (19)

Permitting abortion only in cases of rape, then, creates tremendous problems in proof and evidence.

51 **Rape causes devastating emotional and psychological trauma, lasting months or years.**

To require that a pregnancy resulting from such horror be carried to term aggravates victimization.

52 **Rape is highly traumatic for husbands, boyfriends, entire families of rape victims.**

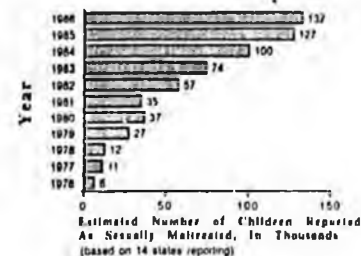
Carrying a resulting pregnancy to term destroys the very fabric of these relationships.

Incest

53 **There were an estimated *327,520* cases of sexual maltreatment of children within families in the United States in 1986 alone. And most cases are not reported.** (20)

Sexual abuse within families is not an isolated occurrence.

54 **The number of sexually maltreated children has increased significantly between 1976 and 1986.** (20)



55 **A pregnancy resulting from incest usually means an emotionally torn *teenager* is facing psychological trauma and increased medical risks.**

56 **A family experiencing incest is a family in turmoil.**

Incest is a severe symptom of a serious problem. A resulting pregnancy increases family trauma.

57 **Incest has extreme emotional and psychological consequences,** sometimes lasting a lifetime. A resulting pregnancy can cause unmanageable psychological problems.

Adolescent Pregnancy

58 **In 1985, 1,031,000 American teenagers became pregnant; of those, 31,000 were younger than age 15.** (21)

59 **Thirteen percent of American teenagers aged 15 to 19 became pregnant in 1985; this compares to 11% in that age group in 1977.** (1)

Unintended pregnancy among teenagers is a continuing problem.

60 **Eighty-two percent of all teenage pregnancies are unintended.** (1)

61 **The health risks of pregnancy are much increased for an adolescent.**

Research indicates that anemia, abruptio placentae and cephalopelvic disproportion are increased in pregnant adolescents. (22)

62 **Adolescents are much less likely than their older counterparts to seek prenatal care; when care is received, it is usually begun much later in pregnancy.**

This increases health risks . . . for the woman and the fetus. (22,23)

63 **Adolescents face serious economic disabilities when confronted with unintended pregnancy.**

Dependence on welfare is common among unmarried teenage mothers; their children in turn may be extremely disadvantaged.

64 **Teenagers who get pregnant and carry to term are much more likely than their non-pregnant peers to drop out of school.**

This seriously decreases their lifetime economic and career opportunities. (11)

65 **Adolescents often lack the maturity to adequately care for a child.**

Parenthood is difficult even under the most ideal circumstances. Immaturity makes parenthood an almost impossible task.

Social and Family Health

Adoption

66 **34,000 children wait to be adopted in the United States. Over 50% are minority. 82% are older, or have special needs.** (5)

Most families wanting to adopt will only accept healthy white children . . . and most want to adopt only babies.

67 **Over 450,000 children now wait in foster homes and state facilities for their fate to be decided.** (5)

Many have been removed from their parents due to abuse and neglect.

Family Violence

68 **Each year, hundreds of newborns are discarded, found in trash cans, plastic bags, wooded ravines.**

Desperate acts by desperate people. Throw-away babies . . . unwanted children. And society weeps.

May 17, 1989. Personal Tragedy. Public Pain.

> **CRIES ALERT MAN TO BABY IN RESTROOM TRASH CAN**
>
> **"It was at the bottom of the trash can with toilet paper stuffed in its mouth and paper piled on top of it. If she wanted it to live, she would have left it on the floor where somebody was sure to find it. Why would anyone do that?"**
>
> *Birmingham Post-Herald*
> *Thursday, May 18, 1989*

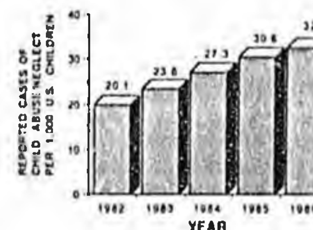
69 **2.1 Million Children were victims of child abuse or neglect in 1986.**

This is a startling 32.8 child-vi...ns for every 1,000 U.S. children. (20)

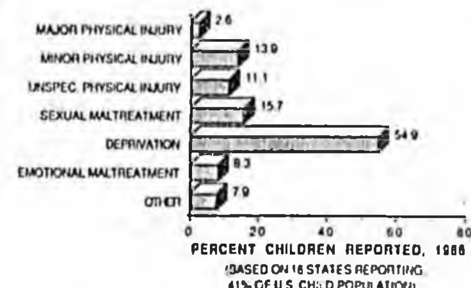
70 **1.3 Million Families reported cases of child abuse and neglect in the United States in 1986.** (20)

71 **Rates of reported Child Abuse and Neglect continue to increase.** (20)

Maltreatment of children is a continuing problem.



72 **Child abuse and neglect takes many frightening forms.** (20)



Note: Because a child may have experienced more than one type of abuse, the total is greater than 100%.

73 **An unintended pregnancy and economic failure . . . recipe for child abuse and neglect.**

Forty-eight percent of all families reporting abuse/neglect receive public assistance; only about 12 percent of all U.S. families receive public assistance. (20)

74 **The mother alone . . . sometimes too much to bear.**

Thirty-three percent of families reporting abuse/neglect are headed by a single female caretaker, compared to 23 percent of all U.S. families with children under 18. (20)

75 Spouse abuse. The unreported, untreated cancer within families. And unintended pregnancy increases the turmoil.

Family Size

76 **An unintended pregnancy can put extreme stress on all family resources.**
Time, money, housing, food . . . are not limitless resources. Families must be able to choose whether another child can be emotionally and economically supported.

77 **Many couples actively limit family size for the well-being of children already in the family.**

78 **Spacing of children within the family must be an individual decision.**
Children born too close together can cause a family physical, emotional, and economic hardship. And an older woman, with children already grown, may not have the emotional or physical stamina to withstand pregnancy, childbirth, and parenthood.

Citizens of the World

79 **Homeless and helpless . . . millions of families and children throughout the world live on the streets, with nowhere to rest or warm themselves.**
Brazil has an estimated 11 million children left helpless on the streets. (5)

80 **Overpopulation in our world leaves millions dying of starvation.**
430 Million people are malnourished in the world. (1)

81 **Every day 40,000 children under age one die from starvation, malnutrition, and preventable infectious disease . . . the children suffer.** (5)

Economics

Family Economics

82 **In 1987, 32.5 million Americans were below the U.S. Poverty Level. That is more than thirteen percent of the U.S. population.**
Poverty is a crippling problem for millions of Americans. (24)

83 **A full 33.6 percent of American families with female heads of household fall below the poverty level.**
Poverty and the single family household make unintended pregnancy a devastating problem. (24)

84 **5.1 million American mothers of children under age 5 are employed full-time; full-time child care must be arranged and paid for.**
Child care is hard to find and expensive . . . especially for the millions of America's poor. (24)

Public Funding and Abortion

85 **For each $1.00 spent by the government on abortion, $4.00 is saved in medical and welfare expenses that would result from an unintended pregnancy.** (1)

86 **Since 1977, the U.S. Congress has barred the use of Federal funds to pay for abortion, except when the woman's life is in danger.**
However, 13 states use state funds to pay for abortions for low income women. The availability of funding for abortions for poor women is a geographic patchwork . . . making abortion legal but unavailable to many of America's poor women (1)

87 **The lack of abortion funding for low income women has resulted in delay in obtaining abortions as women try to raise funds.**
In one study, about 22% of Medicaid eligible women who had second trimester abortions would have had safer first trimester procedures if funding had been available. (1)

88 **In 1985, only 12% of all U.S. abortions were paid for out of public funds, mostly state funds.** (1)

Legal Implications and Society's Price

89 **THE RIGHT TO PRIVACY IS THREATENED. The outlawing of abortion is an extreme example of invasion of privacy.**
It means compulsory pregnancy for women, regardless of individual beliefs and circumstances.

90 **THE SEPARATION OF CHURCH AND STATE IS THREATENED. Arguments against abortion are based mainly on religion-specific ideas.**
The Constitution is built on the belief in the necessity of religious freedom for *all* citizens. The outlawing of abortion threatens this basic belief.

91 **DISCRIMINATION IS ILLEGAL. Restricted access to abortion, where the young and the poor are denied specific legal rights, is discriminatory. Current law denies equal access, due to the lack of funding for poor women.**

92 **FREE THOUGHT IN OUR FREE COUNTRY IS THREATENED. If an idea is opposed by some, can it be outlawed for all? People may differ on an issue as complex as abortion, but as Americans we must agree on the freedom to differ. The Majority of Americans favor the right to safe [illegible] legal abortion, yet a vocal few would outlaw abortion *for all*.**

93 **The national outlawing of abortion will leave women's healthcare bound by geography, politics, and personal economics.**
States will vary on legalization and willingness to pay for abortions for low income women.

94 **The criminalization of abortion causes tremendous legal confusion.**
If abortion is made a criminal offense, who will the criminal be? The woman . . . the doctor . . . other healthcare professionals? What will the punishment be?

95 A ban on abortion may also outlaw post-conception birth control methods, such as some forms of the Pill and the IUD.

These birth control methods act to prevent implantation of the fertilized egg within days following conception, and thus are viewed by some as a method of "abortion".

96 The abortion controversy and the outlawing of abortion decreases interest *and* funding for research in contraception.

97 RU486, known as the "abortion pill", may be successfully used to treat breast cancer, prostate cancer, endometriosis, and Cushing Syndrome.

Manufacture and distribution of RU486 is thwarted in the United States due to the abortion controversy.

The Nations Voice

Majority Opinion

98 American voters consistently state that they favor keeping abortion legal, with 56% of those polled saying that they support "keeping it legal for women to be able to have abortions when they decide to have one."

In fact, 88% of those polled believe that abortion should be an available option under at least certain conditions. (25)

99 A full 63% of Americans polled would oppose the passage of a constitutional amendment that would make abortion illegal. (25)

100 The right to safe and legal abortion is publicly supported by many national organizations concerned with the health and welfare of our nation (26,27), including . . .

American Association of University Women
American College of Obstetricians and Gynecologists
American Federation of Government Employees
American Federation of Teachers
American Public Health Association
Federation of Business and Professional Women
International Ladies Garment Workers Union
League of Women Voters
National Association of Social Workers
National Coalition of 100 Black Women
National Education Association
National Urban League
National Women's Political Caucus
YWCA

. . . And the list goes on.

AND FINALLY . . .

101 THE WOMEN AND THEIR LIVES. For the woman who discovered that the fetus she carries has no brain, only a fluid filled cavity. . . the woman who was raped . . . the 15- year-old high school student who finds herself unintentionally pregnant . . . the mother of four on welfare . . . the 14-year-old whose father assaulted her . . . the woman whose husband abuses her and her three-year-old . . . for all the women struggling for control of their lives, abortion must be legal.

hear their cry . . .

"IT'S MY CHOICE"

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SHATTERING THE DREAMS OF YOUNG WOMEN:

The Tragic Consequences of Parental Involvement Laws

ACLU

AMERICAN CIVIL LIBERTIES UNION

REPRODUCTIVE FREEDOM PROJECT

INTRODUCTION

Every year, over one million young women between the ages of 12 and 19 — become pregnant. The vast majority of these pregnancies are unplanned and unwanted. Although the rate of sexual activity among teenagers is approximately the same in the United States as it is in England, Sweden, the Netherlands, France, and Canada, the United States has the highest rate of teenage pregnancy — primarily because teenagers here are unable to obtain comprehensive, low cost, and confidential birth control and abortion services.

Unfortunately, rather than expanding reproductive health services for teens, by 1990 thirty-two states had passed legislation mandating parental involvement with a young woman's abortion decision. In seven of these states, notification or consent is usually required of both biological, or adoptive, parents. Where implemented, these laws seriously burden a teenager's ability to choose between abortion and childbirth, significantly delay the performance of abortion, and impair the ability of health care workers to provide quality care. As outlined below, these laws punish young women for becoming pregnant; they do not promote family integrity, improve parent-child communication, or help with the teenager's decision-making process.

Do young women have the constitutional right to choose childbirth or abortion?

In 1976, the Supreme Court recognized that a "mature" unmarried minor woman has the constitutional right to decide, in consultation with a physician and without her parent's consent, to choose either abortion or childbirth. Three years later, in *Belotti v. Baird*, the Supreme Court found unconstitutional a Massachusetts parental consent law. But in that decision, the Court also suggested that a state may require parental involvement if it also provides teenage women with the opportunity, through an alternative judicial or administrative bypass procedure, to demonstrate maturity or show that their best interests require a confidential abortion. Since *Belotti*, the Supreme Court has decided five additional challenges to parental involvement laws.

Most recently, in the June 1990 *Hodgson v. Minnesota* decision, the Court upheld as constitutional Minnesota's two-parent notification law, so long as it included a sufficient court bypass mechanism. At the same time, it found unconstitutional Minnesota's two-parent notification statute that contained no bypass mechanism. On the same day, in *Ohio v. Akron Center for Reproductive Health*, the Court upheld as constitutional Ohio's one-parent notification statute because its bypass procedure met constitutional standards. Yet, as this pamphlet demonstrates, the tragic consequences of all parental involvement laws are too serious for public policymakers to ignore. Regardless of the Supreme Court's rulings, these laws are dangerous to the lives and health of young women.

Most teenagers voluntarily tell one or both parents about their abortion.

More than half of the young women seeking abortion voluntarily tell at least one parent about their decision. The younger the teen, the more likely her parents are to know about, and to have even suggested, the abortion. Nonetheless, a significant minority — about 25 percent of teenagers — will not tell their parents nor go to a clinic if parental notification is required. Often coming from severely dysfunctional or single-parent families, most of these teenagers hope to avoid the family crisis that the news of their abortion will cause.

Professional standards require that physicians provide young women with complete information about abortion and its alternatives.

It is standard medical practice to explain the abortion procedure and its medical risks to every patient. Physicians have a legal responsibility, independent of parental involvement laws, to ensure that each patient has given voluntary and informed consent to medical procedures. Even in the absence of parental involvement laws, nearly all clinics encourage young women to discuss their abortion choice with a parent. In an emergency, medical ethics require parental notification.

Young women are capable of making their own health care decisions.

Studies show that teenagers, like adults, can understand and reason about health care alternatives and make abortion decisions consistent with their own sense of what is right for them. Studies also note that adolescents are self-observant and able to provide their health histories as accurately as their parents. Certainly if a minor were too immature to decide to have an abortion, she would also not be mature enough to fulfill her duties as a parent. In fact, studies conclude that young women who choose abortion are more able to realize family goals and avoid later unwanted pregnancies than those teenagers who carry their pregnancies to term.

Recognizing that minors are fully capable of providing informed consent, all 50 states authorize minors to consent either to treatment for sexually transmitted diseases or to general medical care. Twenty-seven states authorize minors to consent to the treatment of pregnancy -- including Caesarian section surgery -- without parental involvement, and to consent to medical care for their children. Abortion is the only reproductive health decision singled out for special treatment.

Many young women are unable or unwilling to involve their parents.

Clinic and court personnel who have experience working with teenagers and their families universally agree that young women show an impressive degree of sensitivity and maturity in deciding whether to involve their parents. Both the state court judges assigned to court bypass hearings in Minnesota and the state's witnesses in the *Hodgson* case testified that teenagers accurately assess their family circumstances. Young women in Minnesota gave many reasons for their decision not to notify one or both parents: their parents' psychiatric or physical illness, drug or alcohol abuse; religious or moral views; likelihood of physical or sexual abuse. Several had no previous contact with the parent.

Involuntary parental notification can be disastrous to any family.

Most parents love their children, but conversations about sexuality and reproduction between loving parents and their adolescent children are often extremely uncomfortable for both sides. Not surprisingly, these kinds of discussions are entirely absent from many parent-child relationships. Although family experts believe that families generally benefit from voluntary and open communication, the same experts agree that compelled communication can destroy any existing good will among family members, particularly when parents are unable or unwilling to react supportively to the news of a daughter's abortion.

Mandatory notification is especially destructive in single-parent and abusive families.

Half of all recent marriages will end in divorce. Close to 60 percent of children born during the 1980's will live in a single-parent family before they reach the age of 18. Many noncustodial parents maintain little, if any, communication with their children. Pregnant adolescents are often perplexed as to why their noncustodial parents should become an important factor in their lives when they previously have offered little or no financial or emotional support.

Woman battering has come to be recognized as the most frequently committed violent crime in the nation. Some estimate that at least one in four women will be battered by a spouse or partner during her lifetime, and that at least 55 percent of children in these families also will be battered. In addition, experts estimate that one in five female children are sexually victimized during childhood; many of these young women will become pregnant. Forcing a young woman to notify her abusive parent of a pregnancy can have dangerous or even fatal consequences. Long-term studies of abusive families reveal that the incidence of violence escalates during pregnancy and during adolescence.

Becky Bell

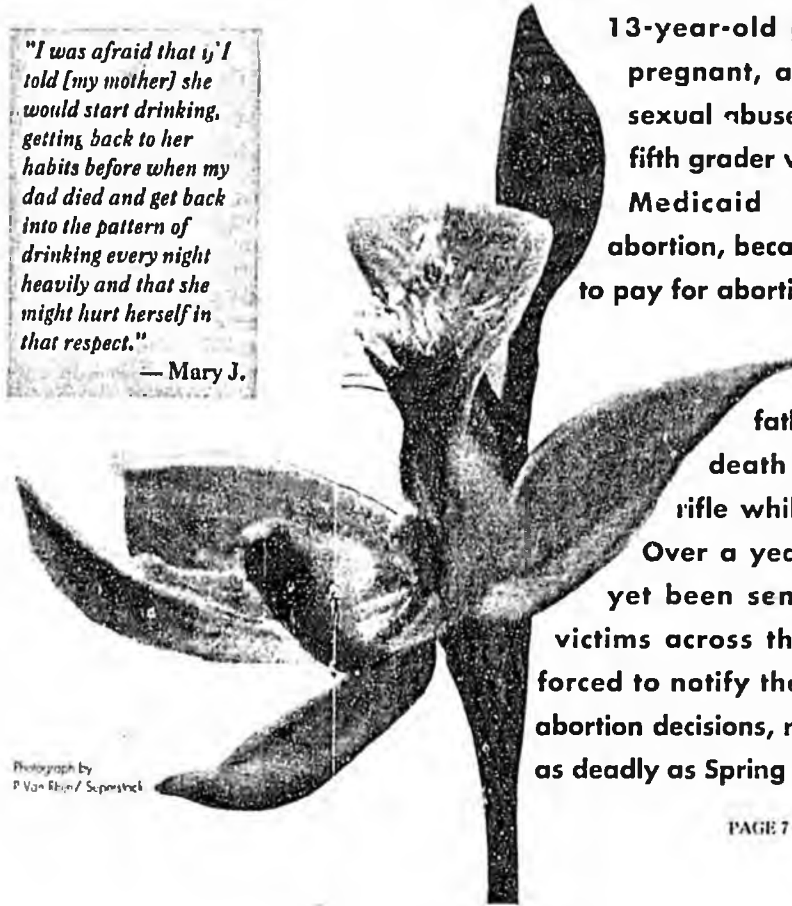
Becky Bell photograph courtesy of the Feminist Majority Foundation and Bill and Karen Bell

Indiana's parental consent law caused the senseless and heart-breaking death of Becky Bell, a 17-year-old Indianapolis high schooler who did not want to "disappoint" her parents by telling them she was pregnant. Rather than seek a legal abortion in neighboring Kentucky, or beg an anti-abortion judge who routinely denied waivers in her home town, Becky did what hundreds of thousands of women did before legalized abortion — she bought "medical care" in the back alley. Becky died of a massive septic infection from the botched abortion, only months before turning 18, when the law would have allowed her the privacy she so desperately sought.

"I was afraid that if I told [my mother] she would start drinking, getting back to her habits before when my dad died and get back into the pattern of drinking every night heavily and that she might hurt herself in that respect."
— Mary J.

"My dad was an alcoholic when we lived with him. I remember him hitting my mom a couple of times and hitting us kids. [I see him] maybe two or three times a year." — Heather P.

"My father has a violent temper. His initial reaction would have been violent and angry and he probably would have hit me."
— Sharon L.



Photograph by P. Van Rhijn / Superstock

In Fruitland, Idaho, Spring Adams, a 13-year-old girl, found herself pregnant, a result of repeated sexual abuse by her father. The fifth grader was unable to obtain Medicaid funding for her abortion, because the state refuses to pay for abortions that are a result of rape or incest. She notified her father, who shot her to death with a .30 caliber rifle while she lay sleeping. Over a year later, he has not yet been sentenced, but incest victims across the country are still forced to notify their abusers of their abortion decisions, risking consequences as deadly as Spring Adams'.

Dr. Lenore Walker, an eminent expert on the psychological effect of battering, has testified that telling a batterer that his daughter is pregnant is "much like showing a red cape to a bull."

Young women already face obstacles when obtaining abortions.

There are no abortion providers in 83 percent of all U.S. counties. In most states, providers are located only in major metropolitan areas, and few public and private hospitals will perform the procedure. This scarcity of providers forces rural women to travel hundreds of miles for services. Because only twelve states provide Medicaid funding for medically-necessary abortions, many women who are too poor to obtain care are forced to carry their pregnancies to term. Even for women with slightly higher incomes, the increasing costs of later abortions may prevent them from getting one. Those women who do find a provider and can afford the cost also face obstacles — frequent harassment by anti-abortion activists who blockade clinic entrances.

Because young women with irregular menstrual cycles take longer to recognize the signs of pregnancy, and because they have difficulty raising the money for an abortion, they often delay longer than older women when seeking an abortion. As a consequence, teenagers disproportionately need second trimester abortions, which are more complicated and costly to perform. Even after acquiring the money and locating a provider, teenagers have difficulty explaining their absence from school, as well as arranging transportation to the clinic and housing nearby.

The court bypass procedures force young women to obtain riskier, more costly abortions.

Although abortion is one of the safest surgical procedures that doctors perform, and significantly safer than childbirth, the later an abortion is performed, the more complicated and costly it is. Nevertheless, where parental involvement laws are in effect, court bypass procedures can routinely delay the abortion procedure from one to three weeks. A panel of the National Research Council, which has specifically recommended against mandatory parental involvement, based their recommendation in part on the "growing evidence that parental consent statutes cause teenagers to delay their abortions."

The Minnesota law that required Cynthia J. to notify both her parents or go to court to obtain permission for an abortion delayed her procedure almost three weeks, substantially increasing the risks to her health.

She missed three days of work and three days of school. Because she had been delayed into the second trimester of her pregnancy, the cost of Cynthia's abortion increased by $125, and the travel to and from St. Paul to obtain permission cost her an additional $150 — all of which she paid from her savings.

Court hearings are frightening and traumatic for young women.

Public defenders, guardians ad litem, and judges all agree that going to court is a frightening experience for young women. Teenagers, most of whom have never been to court before, approach the hearing with apprehension and anxiety — feeling embarrassed, ashamed, or that they have done something wrong. The court bypass process deprives teenagers of the orderly and reassuring experience essential to the provision of quality medical care. The young woman spends her morning under interrogation by strangers in the intimidating and usually chaotic courthouse. She often returns to the clinic tense, angry, or physically ill — in th[illegible]st possible condition to undergo surgery.

Court proceedings expose the private lives of young women to public scrutiny.

Courts and court houses are public places. Young women who go to court can face as many as 20 or more strangers who know they need an abortion. Many teenagers do not seek hearings in their home counties because they are afraid of being recognized. Instead, they endure added

Protecting anonymity is especially difficult in small communities where people know each other well. Kathy, a Minnesota teen, went to a court house where there were only two juvenile court judges. Because one judge was out of town, Kathy had to appear before a judge whom she knew personally and who she knew was opposed to abortion. He was a member of her parish and had a son in Kathy's high school class. Another teenager whose father was a well-known political figure in the city was recognized immediately by the judge. Another young woman entered the judge's chambers, only to find that the court reporter was her neighbor.

expense, further delay, and the burdens of traveling to a distant city — all to preserve some semblance of confidentiality.

Statutory exceptions do not protect young women from the harmful consequences of the law.

Although many laws do not require that "emancipated minors" notify their parents, they do not always define which young women are considered "emancipated." Clinics, which are subject to criminal penalties for violating the law, often require women to obtain a court order rather than risk a misinterpretation of the law. Similarly, the physical or sexual abuse exceptions listed in many state laws do not protect young victims, who often are reluctant to reveal that the abuse exists. Even those young women who want to seek help will stop when they learn that other state laws pertaining to abuse require government authorities to be notified, creating a substantial risk that their confidentiality will be destroyed.

Since no consensus among judges on the appropriate criteria has been reached, the determination of whether a teenager is "mature" or whether the abortion is in her "best interest" rests solely on the individual state court judge — not the young woman's actual developmental status or family circumstances. One judge may examine whether the minor has considered all the available options, another may question whether she can understand her situation. When determining a young woman's "best interests," some judges ask whether it would be in her best interest to have an abortion, others ask whether it would be in her best interest to notify her parents. Recently in Ohio, one judge applied Catch-22 reasoning when he denied a young woman's request for an abortion by finding that she was not mature. "If she was mature," he reasoned, "she would have notified her parents."

Parental involvement laws increase unwanted teenage motherhood.

Parental involvement laws cause some minors who would otherwise terminate unwanted pregnancies to carry to term. In Minneapolis, where complete data is available, the statistics are startling: the birthrate for 15-17-year-olds increased 38 percent compared to only a .3 percent rise for 18-19-year-olds who were not covered by the parental notification law. Prior to the law's enactment, there was no significant difference between the two age groups.

Unwanted motherhood is often devastating to teenagers and their children.

Motherhood is often debilitating educationally, economically, and physically to the teenage mother and her children. National studies show that mothers who give birth in their twenties are twice as likely to have graduated from high school, and four times more likely to finish college, than those who become mothers in their teens. With small children to care for, little education, fewer job skills, and no committed partners, teenage mothers are seven times more likely than other mothers to be poor. The younger the mother at childbirth, the lower her family income. Children of teenage mothers are more likely to be born with a low birth weight, which can lead to serious childhood injuries or illnesses; they are also twice as likely to die in infancy as children born to women in their twenties.

Parental involvement laws are not motivated by a desire to help young women.

The real goal of parental involvement laws is to discourage abortion. Drafted by anti-choice groups that seek to end all abortions, these laws are opposed by organizations traditionally concerned with helping teenagers and their families. To those who would outlaw all abortions, parental notification or consent is but one step in a series of legislative strategies intended to criminalize abortion again. Passage of these restrictions will merely intensify debate, not eliminate the abortion issue from the legislative agenda.

In the first clear test on this issue anywhere in the country, Oregon voters on election day 1990 rejected a ballot measure that would have required a young woman to notify a parent of her abortion decision. Despite pollsters' predictions that the measure would pass by an overwhelming margin — a poll only one month before the election showed that the measure would pass 65 percent to 35 percent — an educational campaign, coupled with old-fashioned election day organizing, changed voters' minds. Through public appearances and television commercials, voters were informed that parental involvement laws do not force minors to talk with their parents. Instead they drive perhaps our youngest and most vulnerable citizens to seek medical care in the back alley.

What laws and policies would really help young women?

Since parental involvement laws do not promote family communication, safeguard teen decision-making, or protect teenagers' health, what measures would accomplish these objectives? We should begin by repealing or substantially modifying all parental consent and notification laws — a crucial step in making reproductive health care and education accessible to young women. We should also provide funding for dramatically increased levels of reproductive health services and counseling — including contraception, abortion, and prenatal, labor, and post-partum care. We should work to institute comprehensive policies of sex and health education in communities and schools. The development of educational, job training, and family support services that relieve the burdens on families, promote communication, and prevent teenage pregnancy are also needed. Although expensive to start up, these programs will more than pay for themselves by reducing the long-term state dependency that teenage motherhood can create.

Whatever services are provided must be accessible. For teenagers, this means they must be located in or near schools or popular hang-outs, be open after school hours, and be free. Perhaps most important, programs must be strictly confidential. Young women who are ready to communicate with their parents about sexuality and reproductive health — including abortion — do so on their own. Mandated parental involvement will only cause those teens who are unable to communicate with their parents to forego necessary care, risking both their lives and health with tragic and sometimes even deadly consequences.

Photograph by Greta Pratt/ Impact Visuals

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PREVENTION. NOT PROHIBITION.

A positive approach for reducing unintended pregnancies and the abortion rate in Minnesota

Coordinated by

MINNESOTA WOMEN'S CONSORTIUM

550 Rice Street, St Paul, MN 55103. (612) [illegible]3-[illegible]

PREVENTION.

A positive approach for reducing unintended pregnancies and the abortion rate in Minnesota

Writer for the Project: Kate Parry
Director of the Project: Julie Luner

The Minnesota Women's Consortium is an association f 170 organizations committed to full equality for women. The Consortium acts as a resource center, referral network, information disseminator and serves as an umbrella for diverse groups of members and non-members to work together on specific projects. "Prevention, Not Prohibition" is one of those projects. It was developed over 7 months of discussions by knowledgeable members, non-members, professionals and public officials. Participation in the Project does not imply endorsement of the entire plan --- each organization has its own priorities. The following organizations had representatives at the discussions:

Abortion Rights Council
American Association of University Women
Arne Carlson Campaign Committee
Commission on the Economic Status of Women
Girl Scouts
GOP Feminist Caucus of MN
Metro University
MN Dept of Human Services, Children Division
MN Extension Service
MN Home Economics Association
MN House Representative Mary Jo McGuire
MN House Representative Sandy Pappas
MN House Representative Gloria Segal
MN House Candidate Kathleen Sekhon
MN N.O.W.
MN N.O.W., District 06 for Choice
MN Nurses Association
MN Nurses Association, Third District
MN Senator Linda Berglin
MN Women's Political Caucus
National Council of Jewish Women
Planned Parenthood of MN
School Nurse Organization of MN
Many individuals

NOT PROHIBITION.

- Minnesotans are practical, sensible people who believe in research, open discussion and public education to help solve our problems. At least, we like to think that's what we believe. But we do not use any of these sensible tools when it comes to our children's sexual activity, contraception, unplanned pregnancies and teen parenthood. We Minnesotans simply don't talk about it; so the problems grow, cost us more money each year and bring poverty and tragedy to too many of our youngsters.

  The dialogue about abortion in Minnesota has become bitter and strident. Yet there is almost no dialogue about the cause of abortion: unwanted and/or unintended pregnancies. There are 15,000 to 16,000 abortions performed in Minnesota each year. This number could be dramatically reduced with two straight-forward proposals: 1) abstinence and 2) contraception.

- Most parents in Minnesota do not talk to their children about sex; they want their adolescent children to abstain from sexual activity. But we must face the painful facts: 22% of 9th grade girls, 35% of 9th grade boys have had sexual intercourse; by the 12th grade it is 60% of the girls and 62% of the boys. These children are at risk of becoming pregnant. Parents, families, churches, schools are not teaching abstinence and we are not teaching self-discipline. If we cannot talk about sex with our youngsters then we must at least make sure that trained teachers and counselors will.

- Most parents in Minnesota want their children to have enough self-esteem and self-confidence to say "no" to activities that will lead them into poverty, social isolation and rejection. But the facts are: lifelong poverty almost always follows a family started by teenagers. Over 50% of women who become mothers before age 18 never complete high school; girls or boys of 18 or 19 without college or vocational training can rarely earn enough to support a family so they depend on AFDC, Medicaid, food stamps, WIC and foster care. We pay that bill and at the same time we rob our children of an independent and economically secure future. If we do not have the confidence to teach self-esteem to our children, we must make sure that our schools, churches and communities do.

- Most Minnesotans believe sex education is taught in the public schools. It is not. A few schools and school districts have excellent curriculum and teachers; but <u>nowhere</u> in state statutes is sex education even mentioned.

  Nor do school-based or community-based clinics exist in any but a very few communities. Young Minnesotans have almost no help in preventing sexually transmitted diseases, even though cases of syphilis are at a 40-year high. There is a statewide toll-free hotline for pregnancy information and referral, but very few people know about it. Our school nurses do a thorough and sensitive job but there are very few of them — only 1 in each district of at least 1,000 students.

- There is no one solution to preventing unwanted pregnancies. This booklet, created by a broad base of community organizations, presents a number of recommendations to challenge the legislature, school boards, parents, adolescents, community leaders, and budget committees. We must begin research, open discussion and public education on these problems. We owe our Minnesota children — and all of our citizens — no less.

The Problem:

Birth control is not available to many Minnesotans.

The Facts:

Use of medical method contraceptives [1] could reduce unintended pregnancies, the abortion rate, and the cost to taxpayers of unintended children born to single and low income women. Almost half of all Minnesota families on AFDC began with a teen birth. [2]

Thirty-three of Minnesota's 87 counties DO NOT provide funding to subsidize medical birth control methods for their low-income residents. (Medical methods include birth control pills, intra uterine devices, condoms and diaphragms.) Those counties are home to 70,560 women at risk of unintended pregnancy because of age or poverty, according to the Minnesota Department of Health.

Minnesota funding for contraceptives has remained virtually stable since 1979. [3] Federal Title X monies for birth control have been cut --- leaving a funding gap the state has failed to fill.

The result: Wealthy women can buy their own birth control. Women on Medical Assistance have access to birth control if they can find a doctor who will accept Medical Assistance reimbursement --- which is not possible in an increasing number of Minnesota counties. The Albert Lea Regional Medical Center in Freeborn County has ceased taking Medical Assistance clients, as has the Owatonna Regional Medical Center in Steele County.

The cost of a year of birth control pills plus examination from a private physician and pharmacy ranges between $282 and $333. [4]

Many teens and working low-income women don't qualify for Medical Assistance. Subsidized services for those groups that easily slip below the poverty line are scarce outside major urban areas.

Some Minnesota counties only subsidize "natural family planning". With a 24 percent failure rate [5] and the need for rigorous monthly record keeping, natural family planning is not a realistic option for many Minnesotans. For the average teenager, it's worse than no method at all because it gives her an illusion of safety that's not really there.

One-fourth of the $2 million the Legislature appropriated in the 1988-1989 biennium for Family Planning Special Projects will not be spent to provide medical method birth control.

Minnesota is experiencing a contraceptive disaster: In 1987 (the most recent year for which statistics are available), 49 percent of women who received abortions in the United States were not using birth control at the time of conception. [6] But in Minnesota, 71 percent of all women who received abortions in 1987 were not using birth control at the time they conceived, according to the Minnesota Department of Health. [7]

Recommended Solutions:

- Significantly increase state funding for family planning grants.
- Ensure access to medical methods of birth control for all Minnesota women regardless of income, age or place of residence.
- Require county boards to use state family planning funds to subsidize medical method birth control options, including methods for men.

What Won't Work:

Using family planning funds only for "natural family planning" and programs that offer teenagers, many of them already sexually active, abstinence as the only other alternative. Remember: In an area as complex as human sexuality, it's wise to beware of simple solutions.

The Problem:

Existing services to prevent teenage pregnancies are inadequate and poorly coordinated.

The Facts:

About 80 percent of all unintended pregnancies are to teens. In 1985, nearly half of the 9,224 Minnesota girls ages 15 to 19 who became pregnant had abortions. [8] Clearly, anyone desiring a reduction in the abortion rate and in the soaring cost of teenage motherhood to society must focus on PREVENTION of teen pregnancies.

Almost half of all Minnesota families on AFDC began with a teen birth. Teen parents stay on welfare longer than most families. A single mother under age 25 is three times more likely to be poor than a couple under 25 with children the same age. Three-fourths of single mothers live in poverty. [9]

A 1985 Minnesota Department of Human Services report found that: [10]

- Two-thirds of women with a child under six years and not currently married were AFDC users in 1980.
- The more children a single woman has, the more difficult it is for her to get off of AFDC.
- Single parenthood as a result of out-of-wedlock births leads to a higher proportion of persistent AFDC use than that produced by single parenthood resulting from divorce.

But the resources these teenagers could use to prevent pregnancies are hard to find, limited in scope and in many rural counties non-existent.

Minnesota teenagers lag behind other teens across the nation in contraceptive use. Minnesota Department of Health statistics for 1987 show almost all Minnesota teenagers seeking abortions were not using birth control at the time they conceived: [11]

PERCENTAGE NOT USING BIRTH CONTROL:

Minnesota:	All women	71%	Nationally:	All women	49%
	18-19 yrs.	80%		18-19 yrs.	51%
	15-17 yrs.	84%		under 17	61%
	under 15	91%			

In a 1983 University of Minnesota study of 650 Minnesota teenagers, 90 percent said lack of access to birth control and embarrassment about discussing contraception were the top influences accounting for unintended teen pregnancy. [12]

While they aren't using birth control, many Minnesota teenagers are sexually active. In 1984, the Search Institute, a private research organization based in Minneapolis, conducted a major survey of 8,000 teenagers for 11 mainstream Catholic and Protestant church bodies and two service organizations. [13] That survey found that 20 percent of 9th graders reported they had had sexual intercourse.

In the 1989 Minnesota Student Survey report conducted by the Minnesota Department of Education, Learner Support Systems, they found that of 91,175 students grades 6 through 12 in Minnesota Public schools, 22 percent of female 9th graders and 35 percent of males reported having sexual intercourse. By the 12th grade, 60 percent of females and 62 percent of males reported being sexually active. [14]

Recommended Solutions:

- Establish an adolescent pregnancy division within the Department of Health responsible for the coordination and development of services for adolescents who are pregnant or who are at risk of pregnancy.
- Standardize the pregnancy prevention programs used by school nurses throughout the state to include access to information on sexuality, birth control, and availability of birth control methods.