Supporting the Sexual and Reproductive Health of Youth in Foster Care After *Roe*

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Bodily autonomy—or the ability to make decisions about our bodies, health, and sexuality without policing or coercion by others—is essential to living a life with dignity, and yet, in this country, it is not guaranteed to all. The U.S. has a long and sordid history of exploiting and controlling people's bodies, especially those of Black, Indigenous, and poor people. For youth in foster care, a glaring lack of autonomy and control over their lives and decision-making is reflected in their lack of bodily autonomy.

Nearly every decision youth in foster care make requires oversight. Their choices are constrained and their actions surveilled. They may, at times, not be able to obtain health services from their provider of choice or forced to waive their right to confidential medical care. Their health care information may be accessed by adults around them without their consent. Child welfare workers, foster parents, and other caregivers may not talk with them about their sexual and reproductive health for various reasons, including lack of comfort or training, or unclear protocols around how to have these conversations or what they should include.[i] Their foster parent or caregiver may proactively interfere with their access to health care by, for example, refusing to take them to doctor's appointments. In some group homes,

Reproductive justice and bodily autonomy are essential for all people, and any attempt to limit that autonomy is detrimental to all people. Policies and practices aimed at controlling reproductive health and well-being are rooted in anti-Black racism. During slavery, enslaved women were considered valuable for their reproductive labor, more valuable the more children they produced, and had no legal control over their bodies or their reproduction.[1,2]

For nearly 100 years after slavery, Black women continued to experience a range of brutalities including medical experimentation and forced sterilization.[3] The recent reversal of *Roe v. Wade* is only the most recent example in a long line of assaults on the autonomy of Black women and another move to bolster White supremacy and the hetero-patriarchal status-quo. While driven by anti-Blackness, the impact of this ruling will be detrimental to the privacy, health, autonomy, and well-being of everyone.

For youth and young adults in the child welfare system, where people of color are overrepresented due to the effect of policies that are grounded in racism and oppress families of color, the impact of the anti-Black racism that drives family separation and attempts at controlling bodily autonomy will have a compounding effect.[4]

[i] In one survey, only a third of child welfare workers reported that they felt adequately trained on this topic. See: https://casala.org/wp-content/uploads/2018/07/Reproductive-and-Sexual-Health-Presentation.pdf.

youth are forced to sign abstinence agreements and others report that staff search their belongings for contraceptives and confiscate those they find.[5] In many states, foster youth must go before a judge if they seek an abortion.

Now, because of how racism has shaped public policies and systems, people who have historically been oppressed, marginalized, and surveilled by systems—including youth in foster care—will undoubtedly be most impacted and further harmed by the Supreme Court's decision to strike down *Roe* v. Wade. In a post-*Roe* world, the bodily autonomy of youth in foster care, which was already limited, will be further surveilled and constrained. Many will be forced into health care decisions they do not want, with lasting consequences.

In response to the overturning of *Roe v. Wade*, this issue brief reviews state and federal policy levers that can support the sexual and reproductive health and well-being of youth in foster care and puts forth recommendations for strengthening coverage and access to comprehensive care and ensuring autonomy and consent for care.

Youth in Foster Care Lack Coverage for and Access to Comprehensive Sexual and Reproductive Health Care

Even before the recent Supreme Court decision to strike down *Roe v. Wade*, youth in foster care were forced to navigate unique barriers to accessing sexual and reproductive health care. They often reported not receiving adequate or timely information about available options or services, difficulty obtaining this information and discomfort with seeking it out, and barriers to accessing contraceptives including condoms.[6] In one study, less than half of youth in foster care reported receiving information on birth control or knew how to access it. In another, foster youth were more than twice as likely as their peers outside the child welfare system to report not using contraception during intercourse in the last year.[7] It is not surprising then that research has found that youth and young women in foster care are up to two times more likely to have an unplanned pregnancy before age 19 than their peers outside the child welfare system,[8] and that youth in care are at higher risk for sexually transmitted infections (STIs).[9]

When children and youth are in foster care, with few exceptions, they are eligible for Medicaid coverage.[10] Medicaid accounts for 75% of all federal family planning dollars, making it an important lever for ensuring youth in foster care can access this care.[11] Yet key barriers exist. The Hyde Amendment, which took effect just three years after *Roe v. Wade*, bans coverage for abortion through federally funded programs, including Medicaid, unless the pregnancy is a result of rape, incest, or endangers a woman's life.[12] As a result, abortion coverage is very limited in the Medicaid program as well as other federally financed programs.[ii] While the Hyde Amendment limits the use of federal funds for abortions, states have the option to use state-only funds to cover abortions for Medicaid recipients under other circumstances, however only 15 states currently do.[iii] The other34 states and the District of Columbia bar the use of their state Medicaid funds for abortions except in limited cases.[13] In addition, several states have attempted to further limit access to abortions for Medicaid recipients.[iv] In some states, regulation explicitly prohibits child welfare agencies from authorizing abortions on the assumption that it violates the Hyde Amendment and jeopardizes their agency funding. Even when states don't have explicit policies prohibiting child welfare from providing notification or consenting to a youth's abortion, caseworkers may impose a prohibition on it for various reasons including uncertainty or confusion around policies relevant to the sexual and reproductive health of youth in care.[14]

Alongside Medicaid, Title X of the Public Health Service Act provides funding to providers, including public health departments and non-profit health centers, that offer comprehensive and confidential family planning and preventive health services.[v] Minors can independently consent to contraception and STI services at federally funded Title X clinics and receive those services confidentially, making it a vital resource for youth in foster care who may be hesitant to otherwise seek out care given concerns around privacy, limited agency over their health care decisions, and lack of control or access to their own health insurance information. Unfortunately, in 2019, the Trump administration issued a Title X rule change that gutted this crucial access to legally protected confidential sexual and reproductive health services

[ii] These include the Children's Health Insurance Program, TRICARE, the Indian Health Service, Medicare, and health insurance for federal employees.
[iii] Fifteen states pay for all or other medically necessary abortions. Additionally, South Dakota does not follow Hyde standards and pays only for abortions when necessary to protect a woman's life.
[iv] Some have tried to use Section 1115 demonstrations to exclude providers that offer abortion services from participating in Medicaid or receiving other federal funds or replaced their Medicaid expansion family planning programs with state-funded programs that cover many of the same services but exclude providers that offer abortion services. Several states have categorically barred providers from offering Medicaid services if they also provide abortions to the general public. These efforts violate the "free choice" provision which guarantees Medicaid enrollees the right to obtain family planning services from any willing and qualified provider and have been consistently blocked by the courts. Others have specifically targeted providers who serve as the largest or the only local provider of family planning services, including targeting individual Planned Parenthood clinics by taking away their Medicaid funding.
[v] Title X constitutes 10% of federal family planning dollars. To a much lesser extent, other programs, including the Health Center Program under Section 330 of the Public Health Service Act, Maternal and Child Health Block Grants, Social Services Block Grants, and Temporary Assistance for Needy Families also finance family planning.

for youth.[15] As a result, roughly 1 in 4 clinics that received Title X money dropped out of the program, and a half-dozen states no longer had any health centers in the program.[16] Although evidence-based Title X guidelines have since been reinstated, the program lacks sufficient funding to meet the need for family planning care.[vi,17] As a result, youth in foster care may go without sexual and reproductive health services including access to birth control and STI screenings if Title X clinics near them remain closed, shut down, or stop offering services.[vii]

Youth in Care Lack Autonomy and the Ability to Consent for Sexual and Reproductive Health Care

Even prior to the reversal of *Roe v. Wade*, youth in foster care had limited bodily autonomy. States frequently fail to provide youth in foster care with the privacy, rights, resources, and support necessary to make informed choices about their sexual and reproductive health. Decisions about their bodies, relationships, and sexual and reproductive health are constrained or dictated by those around them with significant barriers in place in law and policy. The Supreme Court's decision to overturn *Roe* will only make these existing barriers greater, further restricting the rights of youth in care, and limiting access to the supports and services they need to thrive.

Without access to information about available options, youth in foster care are deprived of the ability to make choices about their own sexual and reproductive health and well-being, including choosing to have children, not have children, and to parent the children they have. Youth in foster care often have concerns about privacy that make it less likely they will seek out and access needed services or look for the information they need to make informed choices.

Over the past few decades, the rights of people younger than 18 to consent to a range of sexual and reproductive health services have expanded.[18] Many states explicitly permit all or some people younger than 18 to obtain contraceptive, prenatal, and STI services without parental involvement. However, most states require parental involvement before a legal minor can obtain an abortion.[viii, 19] For youth in foster care, consent for health care is less clear cut. As recipients of Medicaid, they have the right to provide their own medical consent to obtain birth control and can receive confidential services at Title X clinics, if they know what a Title X clinic is and they have the means to access it. But for those seeking abortion care, parental involvement requirements, when the system often limits their involvement with their parents, can delay access, leading to costly, invasive, and harder to obtain later-term abortions.

For youth in foster care, the only alternative to consent from a birth parent or guardian for an abortion is the judicial bypass process which varies from state to state.[ix] In some states, judges require youth to visit a crisis pregnancy center. In others, youth are on their own to find an attorney and to navigate the law. In some states, attorneys often refuse to take these cases, and in several, judicial bypass is commonly denied.[x] For the judicial bypass, a two-pronged test assesses whether the minor is mature enough to decide to have an abortion; and if the minor is not found to be so, if it is in her best interest to have an abortion. There is, however, no clear definition of maturity and a judge has discretion to decide whether a youth is "mature enough." A judge's own biases, views on abortion, or familiarity with a youth's child welfare case, may also impact decisions in these cases.[xi]

Additionally, if a youth lives in one of 10 states that has a total abortion ban, in one of four that has an abortion ban starting at six weeks gestation (prior to when most people even know they are pregnant), or in one of several other states expected to propose new laws to restrict abortion access, they may need to leave the state to access care they need.[xii] For youth in foster care, this is yet another barrier to care, as they will need permission to travel across state lines, support in doing so, and a place to recover when they return. For youth who leave their foster care placement overnight, they also risk losing their placement upon their return.

[vi] Title X appropriations allocations have been flat funded at $286 million for the past eight years, well below the estimated $737 million necessary to meet family planning care needs.

[vii] In one study, researchers estimated that youth living in 8.7 percent of census tracts completely lost access to confidential reproductive care as a result of the Title X rule change, and those living in the Midwest or in rural areas were disproportionately impacted. See: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2793495.

[viii] Just 16 provide exceptions for parental involvement for abortions in cases where a minor is a victim of sexual and physical assault, incest, or neglect.

[ix] In states that have banned abortion, this judicial bypass option is no longer possible, and several states where abortions remain legal are actively exploring laws that would eliminate the judicial bypass and instead require parental involvement for all minors.

[x] A recent story in The Imprint, "What Happens When Foster Youth Want an Abortion—and What Could Soon Change," published on 7/28, highlights the various approaches states take to the judicial bypass process. See: https://imprintnews.org/foster-care/foster-youth-abortion-sabino/66760.

[xi] In a 2007 study, researchers found that judges had significant discretion in implementing judicial bypass often using their own political or religious beliefs to persuade minors to carry their pregnancies to term, requiring that minors receive prolife counseling, or appointing attorneys to bypass hearings who represent the interest of the unborn children. See: https://nyupress.org/9780814740736/girls-on-the-stand/.

[xii] According to the *NY Times*, at least 10 states have banned abortion completely and four others ban abortions starting at six weeks of pregnancy. On Aug. 5, Indiana lawmakers passed and the governor signed a near-total ban on abortion. This law will go into effect on Sept. 15. See: https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html.

Recommendations

Given that youth in foster care already face barriers to accessing sexual and reproductive health care and recognizing that their bodily autonomy will be further surveilled, constrained, and harmed as a result of the overturning of *Roe v. Wade*, it is imperative that we look to opportunities to take protective actions. Below we highlight recommendations intended to strengthen coverage and access to comprehensive care and ensure autonomy and consent for care for youth in foster care.

Priority Actions: Strengthening Coverage for and Access to Comprehensive Care

Congress *should* provide additional funding for Title X providers bringing funding levels up to the estimated $737 million necessary to meet family planning care needs.[20]

Centers for Medicaid and Medicare Services (CMS) *should:*

- Prohibit states from categorically excluding abortion providers, including Planned Parenthood, from the Medicaid program.
- Prohibit family planning waivers (authorized by section 1115) that allow states federal permission to exclude participation by any providers that offer abortions.
- Initiate compliance actions in states that restrict access to family planning providers in ways that are not permitted by federal law.

States *should*:

- Use state-only funds to pay for abortion services through their Medicaid programs.
- Increase funding for sexual and reproductive health services to ensure free access to care.
- Ensure access to prescription contraceptives over-the-counter and at no-cost.
- Identify additional funding streams to be used to support sexual and reproductive health, including abortions, that are not covered by Medicaid.
- Remove barriers to ensure that foster youth can easily utilize Medicaid benefits until age 26, including access to sexual and reproductive health care.
- Expand patient-centered medical home models for foster youth, with providers that can address the full range of sexual and reproductive health care needs, including supporting access to various contraceptive methods.[xiii]
- To ensure that all youth can access affirming sexual and reproductive health care, eliminate discriminatory and harmful practices including categorical prohibitions on the use of state Medicaid dollars for services related to transgender health coverage and care.[21]

Child welfare agencies *should*:

- Ensure youth are informed of their sexual and reproductive health rights and know where and how to access Title X clinics.
- Ensure youth can access sexual and reproductive health services by providing transportation to and from appointments, helping to identify providers, (if requested) making appointments, and, ensuring that youth are up-to-date on their annual medical appointment.
- Engage youth in foster care in assessments of barriers to accessing sexual and reproductive health services to understand their concerns and needs and ensure these are addressed.
- Have clear policies regarding the sexual and reproductive health of youth in care and mandate training for case workers, judges, foster parents, and other caregivers to ensure that adults supporting youth are knowledgeable on this topic, understand their roles and responsibilities, and can support youth's sexual and reproductive health and well-being.

[xiii] Patient-centered medical homes have been found to improve access to sexual and reproductive health services for foster youth. An evaluation of the SPOT (Supporting Positive Opportunities with Teens) COACH (Creating Options and Choosing Health) clinic, a medical home for youth in foster care found that it was able to increase access to hormonal contraception (from 53% to 85%) for young women in foster care and encourage them to return for multiple contraceptive visits.

Priority Actions: Ensuring Autonomy and Consent for Care

***States** should*:

- Implement policy to ensure that youth are able to independently consent to sexual and reproductive health care and require that any communications about those services remain confidential.[xiv]
- Ensure foster youth can consent to an abortion without the oversight of a parent or legal guardian, or judge.

***Child welfare agencies** should*:

- Have clear policies that: (1) ensure youth are able to confidentially obtain information and to make appointments for sexual and reproductive health care services; (2) guarantee the protection of young people's confidentiality; (3) build accountability structures and processes to ensure that youth rights are protected and respected; and (4) train youth on their rights and how to self-advocate for their sexual and reproductive health needs.
- Create processes and develop contracts to ensure youth have access to sexual and reproductive health services regardless of race and ethnicity, and sexual orientation and gender identity and expression (SOGIE).
- Record only the minimum needed information on youth's sexual and reproductive history in case files and case records, and ensure youth are consulted about this information.[22]
- Issue guidance or rules that ensure case workers support youth in decision making and autonomy over their body and their choices.
- Clearly communicate and enforce the priority of youth privacy to all workers, foster parents, and staff that interact with youth.
- Co-design policies with youth around sexual and reproductive health as well as core training for case workers and foster parents that includes information on youth sexual and reproductive health rights and the role of child welfare partners in supporting those rights.[23,24]

[xiv] See Advocates for Youth's model legislation, Minors & Youth Access to Sensitive Health Services Act (MY Access).

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