



Life After *Roe*: Supporting Women and Families Facing Unexpected Pregnancies

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Key Points

- In the post-*Roe v. Wade* world, state governments will revise laws and regulations about abortion access. All states, whether their elected officials favor abortion access or decide to restrict access to the procedure, should review laws and programs affecting women facing unexpected pregnancy.
- For many women, unexpected pregnancy is accompanied by financial hardship, health issues, substance use disorders, housing needs, and other challenges. To help these women, states should review benefit and service strategies to help ensure women have the support they need for healthy pregnancies and babies, whether they live in states that allow abortion or ones that seek to restrict it.
- The federal government can help by implementing a balanced, pro-family tax credit; increasing appropriations for existing maternal and child health safety-net programs; and creating a new maternity choice voucher program to provide immediate, supplemental support to women facing unexpected pregnancies.

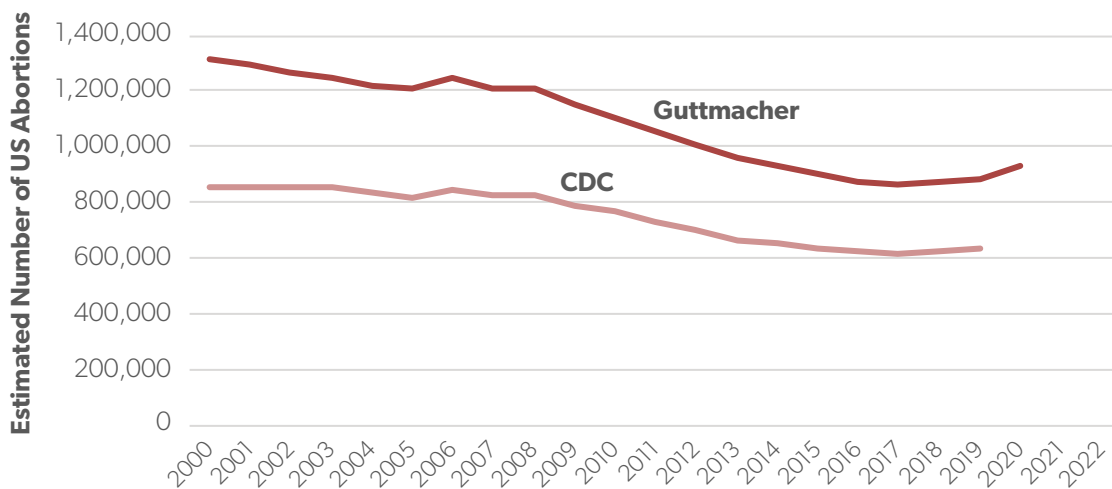
On June 24, 2022, the US Supreme Court decision in *Dobbs v. Jackson Women’s Health Organization* held that the United States Constitution does not protect abortion as a constitutional right, overturning previous Court opinions in *Roe v. Wade* and *Planned Parenthood v. Casey*. The *Dobbs* ruling closes the era in which abortion policy was set at the national level and begins a new era in which abortion policy will be determined by state legislatures and governors. It also means federal and state governments will have more to do than just regulate the abortion procedure. Especially in states that are likely to restrict abortion, governments will need to begin a thorough review of supports and benefits extended to women who can no longer terminate a pregnancy.

Federalized abortion policy has been at the heart of social policy debate for decades. The polarized political

age we live in was created and shaped in no small part by the *Roe* decision itself. As Chief Justice John Roberts said in his *Dobbs* concurrence, this “is a serious jolt to the legal system”—and not just the legal system but our politics and the administrative state as well.¹ Elected officials—local, county, state, and federal—who have had the ability to defer to the Court for 50 years on abortion policy now face a reckoning: They must determine how to fashion abortion policies that reflect public attitudes and plan to support low-income pregnant women and their infants in jurisdictions where access to abortion is limited or nonexistent.

This will be difficult and contentious work—the kind elected officials, grown used to symbolic politics channeled through social media, are badly out of practice in performing. Abandoning women experiencing

Figure 1. Abortion Trend, 2000–20



Source: Author’s calculations using Katherine Kortsmit et al., *Abortion Surveillance—United States, 2019*, Centers for Disease Control and Prevention, November 26, 2021, <https://www.cdc.gov/mmwr/volumes/70/ss/ss7009a1.htm>; and Rachel K. Jones et al., “Long-Term Decline in US Abortions Reverses, Showing Rising Need for Abortion as Supreme Court Is Poised to Overturn *Roe v. Wade*,” Guttmacher Institute, June 15, 2022, <https://www.guttmacher.org/article/2022/06/long-term-decline-us-abortions-reverses-showing-rising-need-abortion-supreme-court>.

unexpected or undesired pregnancies to a world in which they can neither get an abortion nor find adequate social and financial supports for pregnancy and childbearing seems both contradictory and callous, a betrayal of a genuine pro-life stance. For the pro-life movement, the long-sought demise of *Roe* marks a starting rather than ending point.

Dobbs creates new challenges—but it also contains new opportunities for advancing how we support women facing unexpected pregnancies. With the constitutional issue now decided, people of goodwill—pro-life and pro-choice—who share a commitment to the value and dignity of the human person may be able to work together to fashion compromises that affirm the intrinsic value of women *and* the children they bring into the world.

Tough debates lie ahead. If we remain polarized between an unrestricted abortion policy and a sometimes punitive pro-life stance that insists on pregnancy and skimps on financial and social resources, we will demonstrate only that neither side was ever sincere in its arguments about either human dignity or what a compassionate response to dignity entails. Life after *Roe* will require open hearts and open checkbooks, public and private, to prove otherwise.

This report outlines a few key policies that can provide a foundation for state and federal policymakers

to use to build a welcoming and affirming culture for mothers facing unplanned pregnancies and the children they bring into this world. The report first examines the current landscape of unexpected pregnancy and abortion and then moves to a set of policy recommendations that could be used to strengthen the financial and social safety net supporting pregnant women and families. These proposals are far from exhaustive. In fact, they may only scratch the surface of the compassion and creativity the moment demands as we step into the post-*Roe* era. But they are a start.

Current Landscape of Unexpected Pregnancy and Abortion

Understanding the demographic and geographic distribution of unexpected pregnancies and abortion is foundational to building policy that will serve the women and children most in need of support. This report relies on data from the Guttmacher Institute, one of the nation’s leading authorities on pregnancy, reproductive health, and abortion, and the Centers for Disease Control and Prevention (CDC), which also gathers a wide array of data on pregnancy and abortion.²

Guttmacher finds that nearly half of US pregnancies are unintended and that the unintended pregnancy

rate is highest among low-income women—and as much as five times higher for women with incomes at least 200 percent of the poverty line.³ Of these unplanned pregnancies, about 40 percent end in abortion, while 60 percent are carried to term.⁴ As shown in Figure 1, between 2000 and 2019, Guttmacher and the CDC find a decrease in incidence of abortion and record a slight increase since 2019.

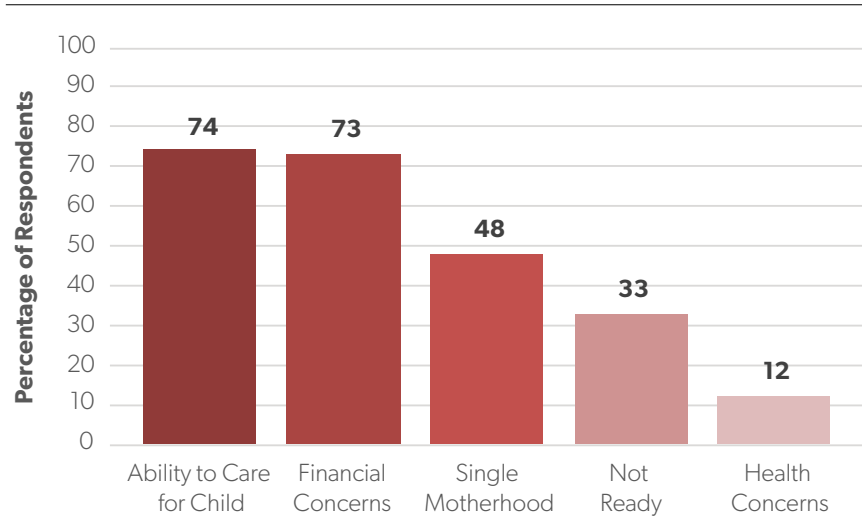
Of women who have abortions, 74 percent do so because they are concerned about their ability to care for dependents and the way pregnancy might interfere with education or work, 73 percent have financial concerns, and 48 percent cite relationship issues or concern about becoming a single mother.⁵ Reasons for pursuing abortion are presented in Figure 2. Another study finds that most women cite multiple of these challenges as playing into their decision to have an abortion.⁶

Women who decide to have abortions tend to be disproportionately younger, lower income, unmarried, and minority. In 2019, more than half of all abortions were accounted for by women in their 20s.⁷ Adolescent women had the highest ratio of abortions to population (i.e., adolescent pregnancies were more likely to end in abortion than were pregnancies in other age categories). According to the CDC, slightly over 85 percent of women who have abortions are unmarried.

Health Insurance and Health Care Challenges

Health insurance coverage is a major concern for pregnant women. Pregnant women, especially low-income pregnant women, tend to face more uncertain employment statuses, challenging family structure and relationship problems, and higher risk of maternal health conditions. Unstable social conditions and coverage eligibility can lead to high rates of churn in insurance coverage. Even for privately insured families,

Figure 2. Reasons for Pursuing Abortion



Source: Author's calculations using Lawrence B. Finer et al., "Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives," *Perspectives on Sexual and Reproductive Health* 37, no. 3 (September 2005): 110–18, <https://www.guttmacher.org/journals/psrh/2005/reasons-us-women-have-abortions-quantitative-and-qualitative-perspectives>.

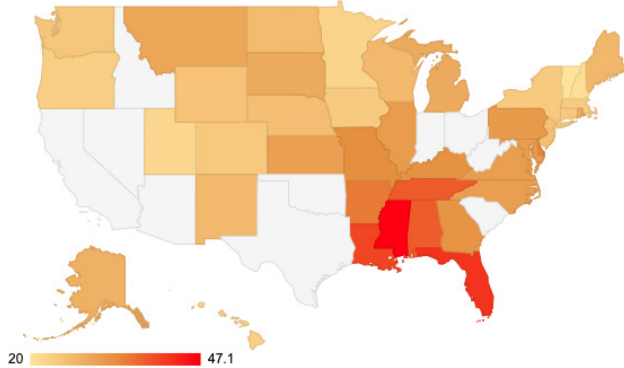
the out-of-pocket costs for childbirth are, on average, \$3,000.⁸ A 2021 study found that 60 percent of pregnant women were unable to afford health care, 24 percent faced unmet health care needs, and 54 percent faced general financial stress.⁹

Because low-income women have higher rates of unexpected pregnancy, public programs are often the primary health insurance for them. Medicaid pays for almost half of all births in the United States and 65 percent of births to black mothers.¹⁰ Eligibility for Medicaid is determined by household income, family size, age, disability, and other factors that vary by state and covers pregnancy, labor, delivery, and perinatal care for 60 days postpartum.¹¹ Medicaid's Child Health Insurance Program (CHIP) provides care and insurance for children in low-income families up to age 19, including well-baby and well-child visits, dental care, vaccines, and behavioral health.¹²

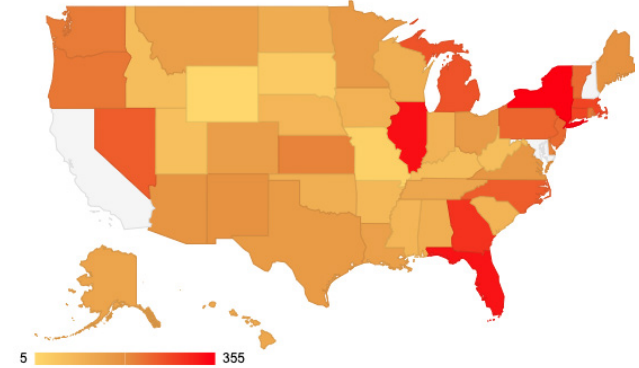
Some of the states with the most stringent laws against abortion already have the highest rates of infant and maternal mortality.¹³ By some estimates, banning abortion will likely increase maternal mortality largely by forbidding abortion among women who are already at elevated risk of life- or health-threatening complications due to inadequate care and poverty.¹⁴

Figure 3. Geography of Unexpected Pregnancy and Related Variables

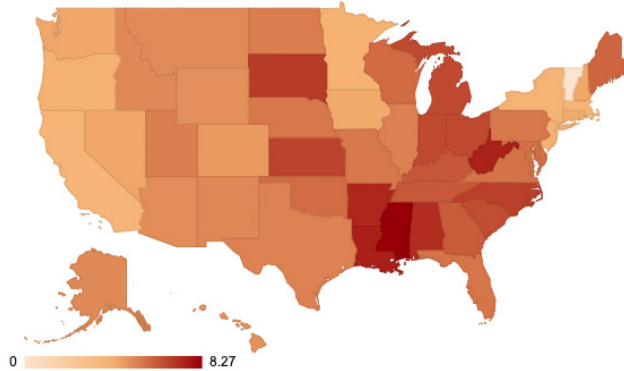
Panel A. Unplanned Pregnancy Rate
Percentage of Live Births That Are Unintended



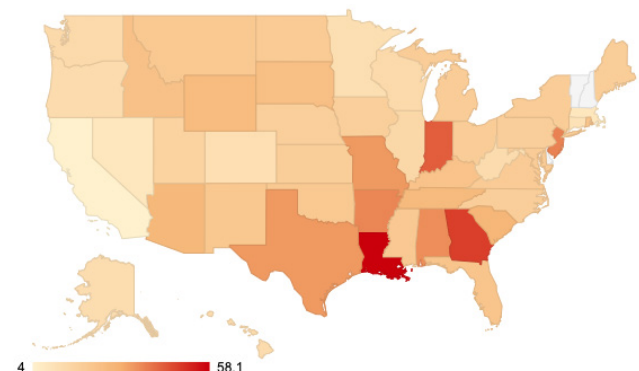
Panel B. Abortion Ratio
Abortions per 1,000 Live Births



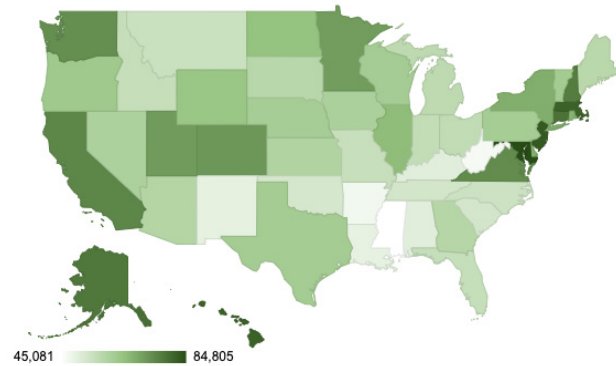
Panel C. Infant Mortality Rate
Deaths per 1,000 Live Births



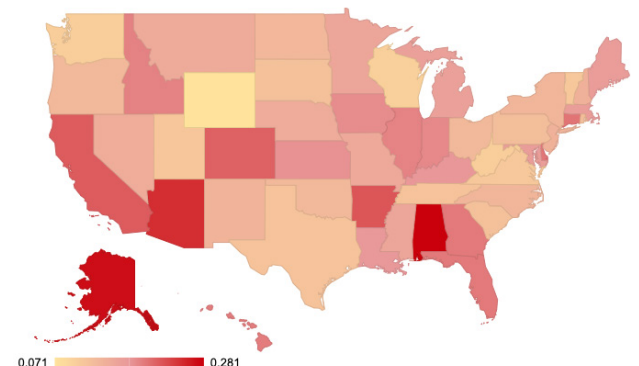
Panel D. Maternal Mortality Rate
Deaths per 100,000 Births



Panel E. Median Household Income
Median Household Income in 2020

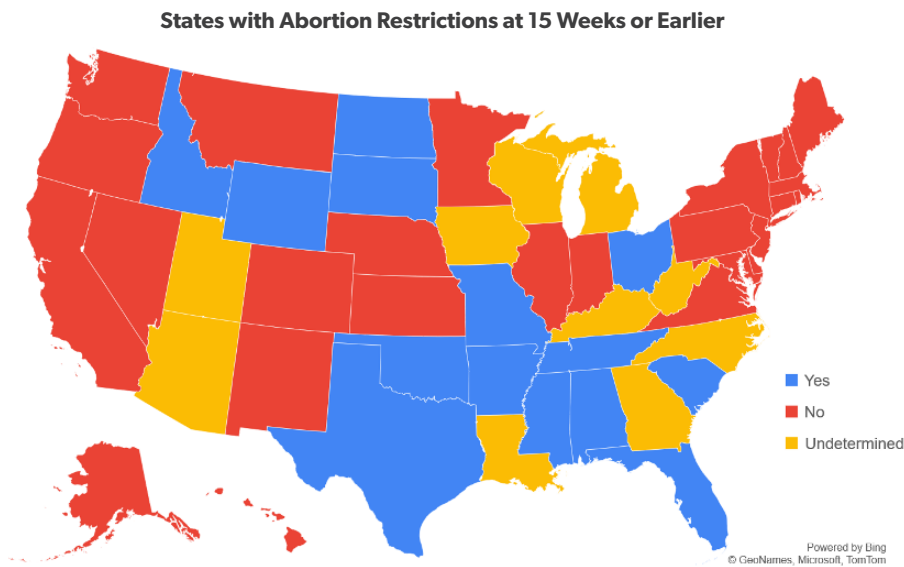


Panel F. Child Poverty Rate
Percentage of Children Below the Poverty Line



Source: Author's calculations using America's Health Rankings, "Public Health Impact: Unintended Pregnancy," https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/unintended_pregnancy/state/ALL; Centers for Disease Control and Prevention, Infant Mortality Rates by State, March 3, 2022, https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm; World Population Review, Maternal Mortality by State 2022, <https://worldpopulationreview.com/state-rankings/maternal-mortality-rate-by-state/>; US Census Bureau, Median Income in the Past 12 Months (in 2020 Inflation-Adjusted Dollars), 2020, <https://data.census.gov/cedsci/table?q=median%20income&g=01000000US%240500000&tid=ACSST5Y2020.S1903>; and Samuel Stebbins, "Mississippi, Louisiana Are Among the States with Most Children Living in Poverty," *USA Today*, November 13, 2020, <https://www.usatoday.com/story/money/2020/11/13/how-many-children-live-in-poverty-in-your-state/114707092/>.

Figure 4. Geography of Abortion Restrictions



Note: This map is likely to change as state courts decide on the legality of each state's abortion laws. Some states, which have laws currently blocked or in court, are likely to see their laws legalized; others are unlikely.

Source: Author's calculations using Megan Messerly, "Abortion Laws by State: Legal Status of Abortion Changing Day-by-Day After *Roe v. Wade* Overturned," *Politico*, July 6, 2022, <https://www.politico.com/news/2022/07/06/abortion-laws-states-roe-overturned-00044127>.

Geography of *Dobbs*

The challenges posed by the post-*Roe* era present a relatively well-defined policy problem. For middle- and upper-income women, abortion will likely remain widely available, either by travel to states with few or no abortion restrictions or through increased use of medical (i.e., pharmaceutical) abortions. The outlook for pregnancies among low-income women is quite different. For lower-income women in states where abortion access changes, the landscape of options will change dramatically.

As demonstrated in Figure 3, unintended pregnancies (Figure 3, Panels A and B) tend to be concentrated in states with low per capita income (Figure 3, Panel E), elevated maternal and infant mortality (Figure 3, Panels C and D), and higher rates of child poverty (Figure 3, Panel F).¹⁵ These are also states that already have lower abortion-to-live-birth ratios.¹⁶ In 2019, Alabama had an unintended pregnancy rate of 40 percent and an abortion ratio of 6.3 abortions per 1,000 live births.¹⁷ By contrast, New York had an unintended

pregnancy rate of 26 percent in 2019 and an abortion ratio of 20.3 abortions per 1,000 live births. There is important, but different, work to do in both types of states to foster social and cultural conditions more welcoming to human life.

As already noted and seen in Figure 4, many of the states that have or likely will restrict or ban abortion also tend to have higher rates of maternal and infant mortality and higher rates of child poverty. Lower income levels in these states (Figure 3, Panel E) will also make it difficult for state governments to fund creative responses to the *Dobbs* era. This combination of circumstances means that more restrictive abortion policies in these states, undertaken by themselves, will

tend to aggravate a range of negative socioeconomic outcomes for women and children.

In states where abortion access is unlikely to change (e.g., California, Illinois, and New York), an increase in resources to pregnant women might play a somewhat different, but no less vital, role in abortion policy. As noted earlier, a majority of women say that they decide to pursue abortion because they cannot afford the child or face employment, educational, or other constraints. Enhancing benefits and services to high-need populations would be a step toward making pregnancy and child-rearing a more viable alternative than it currently is in states with *Roe*-like abortion policies.

In other words, what we ought to seek—and what we should have been seeking since 1973—is a society in which we regard the interests of mother and child as a unity, rather than retreating to a posture that pits one against the other. Below is a list of policy proposals that could move us toward that objective and, as importantly, help bring abortion supporters and opponents closer together on questions of how to promote healthier pregnancies and infants.

Table 1. CTC Proposals

Proposal	Explanation	Eligibility	Costs
Build Back Better (Biden Administration) ²¹	<p>Build Back Better would make the changes to the CTC in ARPA permanent: The credit would remain fully refundable at the ARPA benefit level. It would not replace other programs (e.g., earned income tax credit).</p> <p>Families would receive \$3,000 per child age 6–17 and \$3,600 per child under age 6.</p>	<p>Phase-In: None. Families can receive the full benefit amount, up to \$150,000 for married couples or \$112,500 for single parents.</p> <p>Phaseout: Credit declines to \$2,000 at income levels of \$150,000 (married) or \$112,000 (single) and remains there up to \$200,000 for single filers or \$400,000 for married joint filers, above which it is eliminated.</p>	\$222.5 billion in 2022 ²²
AEI-Brookings Working Group Report ²³	<p>This proposes that the minimum income eligibility, under which families must have \$2,500 of income to be eligible for the refundable portion of the CTC, is eliminated.</p> <p>The group has not stated the exact benefits.</p> <p>The group agreed that a way to increase targeting for low-income children should be explored. Most members of the working group favor a CTC paid monthly, some prefer a yearly credit, and others advocate for a system of borrowing against future credits.</p>	<p>There is disagreement on whether the CTC should include work incentives in the form of a phase-in and whether the payments should be monthly or annual.</p> <p>Some members were in favor of reducing the benefit for higher-income households to offset costs. This would mean that the phaseout would begin at lower income levels and be steeper.</p>	—
Working Family Credit ²⁴	<p>This would replace the earned income tax credit, CTC, and head-of-household tax preference with one child-related benefit.</p> <p>Benefits to working families would include a maximum of \$6,000 for a family with one child, \$9,000 for a family with two children, and \$12,000 for a family with three children.</p>	<p>Phase-In: The credit would phase in, reach the maximum amount, and then stay there until an income threshold of \$30,000 is hit for single parents or \$50,000 for married couples.</p> <p>Phaseout: The credit would phase out in different ways, depending on marital status and number of children.</p>	\$231 billion
Mitt Romney–Richard Burr–Steve Daines Proposal ²⁵	<p>This proposal would replace the CTC, the child and dependent care credit, TANF, and head-of-household tax filing status.</p> <p>The maximum benefit for this plan would be \$350 a month for each young child (\$4,200 per year) and \$250 a month for each school-age child (\$3,000 per year).</p>	<p>Phase-In: Families must have made \$10,000 in the previous year to qualify for the full child benefit. If they earned less than that amount, they would “receive a benefit reduced in proportion to their earnings.”²⁶</p> <p>Phaseout: The credit would stay constant until the normal phaseout thresholds of \$200,000 for single filers and \$400,000 for joint filers, at which point it would be reduced by \$50 for every \$1,000 above the threshold.</p>	The costs of the credit are intended to be offset by the replacement of these programs and reforms of the earned income tax credit.

Source: Author.

Child Tax Credit

A policy proposal commonly discussed and referenced regarding supporting women and families is the child tax credit (CTC). The CTC increases the income of low- and moderate-income parents raising children. Debates on the CTC policy are well-documented by other sources and experts.¹⁸ *Dobbs*, however, raises new moral issues relative to CTC policy, particularly on the question of how to balance increased support to low-income families while not undermining work incentives.

The CTC was established in 1997 as part of the Taxpayer Relief Act, with the goal of reducing the tax liability of parents and increasing family disposable income.¹⁹ Eligibility was expanded to cover more middle- and upper-income families in the 2017 Tax Cuts and Jobs Act.²⁰ To provide relief for families during the COVID-19 pandemic, the American Rescue Plan Act (ARPA) temporarily increased the CTC and expanded its eligibility. Over the past 18 months, Congress has been debating proposals to renew the CTC provisions of ARPA, resulting in various approaches, several of which are summarized in Table 1.

As noted above, developing a workable CTC policy that helps families without fostering dependency is difficult. Regardless of which approach is taken, significant trade-offs will be driven by whether policymakers favor greater progressivity (i.e., helping the poorest women and children most) or prioritizing work incentives as a better way to increase low-income families' incomes in the long term. From the standpoint of improving conditions for low-income women facing unplanned pregnancies without access to abortion, it is probably preferable to lean toward more generous and progressive credits.

Maternal and Child Health Block Grants

Currently, health-related costs of pregnancy and delivery and the ongoing health insurance costs for low-income women and their children are paid primarily by Medicaid and CHIP. Another source of funding for mothers and children during pregnancy and in the first few years of life comes from Title V of the Maternal and Child Health (MCH-V) Block Grant Program. In fiscal year 2022, Congress allocated \$747.7 million to MCH-V programs, which helped provide services to 60 million

people.²⁷ Under MCH-V, Congress establishes the categories of services that can be funded but allows states to allocate resources toward priority needs, including prenatal, postnatal, child, and adolescent health; strengthening childcare services and community-based systems of care; and establishing and operating hotlines for application services.²⁸

The MCH-V Block Grant Program requires states to match every \$4 of federal funding with \$3 of state and local funding. Congress could incentivize expansion of services through the block grant by adjusting the match to make it more generous (e.g., \$5 federal to \$2 state funds) and encourage states to focus these additional resources on evidence-based programs and innovative supports for pregnant women and their children. To help broaden the network of programs providing services, Congress might also consider creating a maternal choice voucher (outlined below) within the MCH-V Block Grant that pregnant women could use to purchase pregnancy- and family-related services from qualified providers of their choice.

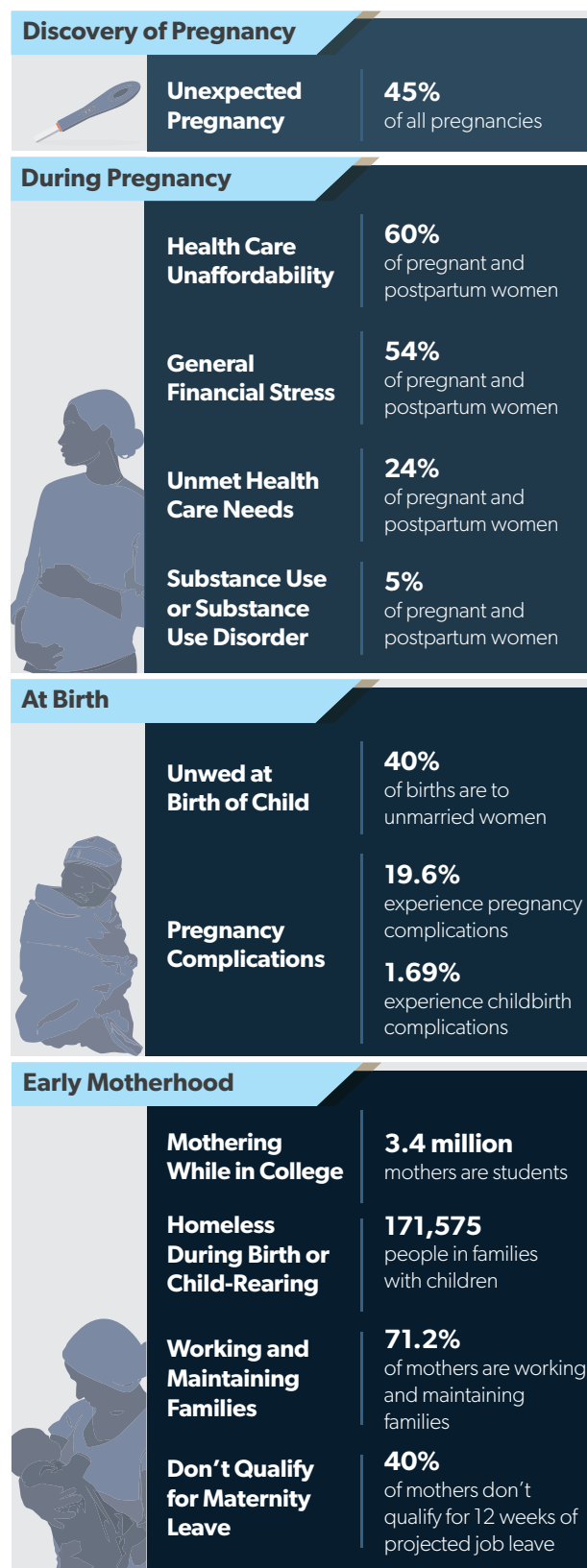
Maternal Choice Voucher Program

In addition to expanding support to programs and providers through the block grants, increasing flexible financial support is vital given the range of circumstances and needs low-income women face. As Figure 5 displays, each mother faces a unique set of needs during and after pregnancy, including financial challenges; employment difficulties; pregnancy complications that may result in ongoing expenses; housing, substance, and mental health problems; and other family issues.

As a supplement to traditional service offerings, a flexible, mother-directed voucher could infuse resources into what are often challenging circumstances and provide women facing unplanned pregnancy with additional help in meeting basic needs. If the state chose to implement vouchers, the vouchers would be available to mothers who already qualify for services under MCH-V, defined as low-income and at elevated maternal risk for death, disease, and injury.²⁹

Vouchers such as these prioritize consumer choice, including the option to use the voucher at faith-based treatment programs. This type of choice-focused structure is important to ensure low-income pregnant women can tailor services to their particular needs from

Figure 5. Potential Challenges in Pregnancy and Childbearing



Source: Author.

service providers that are easily accessible in their communities, including community-based and religiously affiliated programs.

A final reason to consider the use of maternity vouchers is evidence that choice-focused policies can help enhance outcomes for high-need populations above what traditional approaches achieve.³⁰ An evaluation of housing choice vouchers for homeless families showed that they reduce homelessness and instability in housing by nearly 80 percent and significantly improve other markers of social stability, such as school attendance.³¹

There is a risk in such a program that women facing difficult socioeconomic circumstances might decide to become pregnant to qualify for the additional resources offered by such a voucher. While that risk will likely be low, the federal government could adopt a policy that served to incentivize states in devoting more resources to pregnancy prevention via promotion of birth control, abstinence education, or both. Such an incentive program might also provide MCH-V bonuses to states that succeeded in reducing both unplanned pregnancy and abortion rates.

Substance Use Disorder Treatment for Pregnant Women

For women who are pregnant and experiencing substance use disorders (SUD), ensuring substance use treatment and counseling is vital to supporting a healthy pregnancy and child. Annually, 5 percent of pregnant mothers (almost 320,000) in the United States use one or more addictive substances or have SUDs.³² The use of addictive substances during pregnancy can cause neonatal abstinence syndrome (NAS) (i.e., physical withdrawal upon birth) among newborns. Substance use in pregnancy also doubles the risk of stillbirth, depending on the drug involved.³³ Hospitalizations for NAS births cost \$572 million in 2016, and fetal alcohol spectrum disorder births have a lifetime cost of \$2 million per affected individual.³⁴

Programs that specialize in helping pregnant women overcome substance abuse have demonstrated that they can effectively enroll pregnant women in substance abuse recovery programs.³⁵ Many of the programs that offer substance use assistance for pregnant and postpartum women also offer ancillary services such as

childcare, transportation, and domestic assistance. The maternity vouchers outlined above could also be used to help pay for SUD treatment.

One of the main challenges, however, is the dearth of SUD treatment programs for pregnant women. As of 2018, only 23 percent of substance use facilities offered programs specifically designed for pregnant and parenting women.³⁶ To help fill this program supply gap, the Substance Abuse and Mental Health Services Administration (SAMHSA) released a \$10 million discretionary grant program earlier this year to provide low-income pregnant and postpartum women and children with comprehensive SUD treatment and recovery support services in locations with barriers to treatment.³⁷ The program extends services to fathers, partners, and other family members.

To meet the needs of pregnant, low-income women with SUDs, funding for programs to provide treatment should be expanded. Congress should increase funding for SAMHSA's discretionary grant program and prioritize increases in the agency's existing \$3.5 billion of substance abuse block grants for use in prevention, treatment, and recovery efforts targeted to pregnant and postpartum women.³⁸

States should also review policies that discourage mothers and pregnant women from seeking SUD treatment. Roughly half of states criminalize substance use during pregnancy. A RAND Corporation study found that states with these policies for substance use during pregnancy have higher rates of NAS.³⁹ States should be encouraged to revisit criminalization policies in combination with expanded access to SUD treatment.

Expanding Nurse Home Visiting

One of the few rigorously evaluated programs for improving physical, educational, and social outcomes for children is nurse home visiting, a program model that deploys registered nurses to educate and mentor pregnant and parenting low-income mothers.

The success of home visiting programs is built on 30 years of careful development by David Olds, former Harvard professor and principle designer of the country's first nurse home visiting programs. In 2003, Olds created the Nurse-Family Partnership (NFP), a non-profit nurse home visiting program that has served over 366,000 families.⁴⁰

Effectiveness of Maternal, Infant, and Early Childhood Home Visiting Programs

Evaluation of Maternal, Infant, and Early Childhood Home Visiting programs has shown improvement in rates of child abuse, neglect and maltreatment, and school readiness.

- 66 percent of programs reduced child abuse.
- 85 percent of programs increased school preparedness.
- 70 percent of programs reduced crime potential and involvement.
- 85 percent of programs improved economic self-sufficiency.
- 85 percent of programs improved coordination of community resources.⁴⁵

Independent evaluation of NFP has found returns of as much as \$5.70 for every \$1 spent on the program, primarily by reducing government expenditures on Medicaid, Temporary Assistance for Needy Families (TANF), and nutrition assistance.⁴¹ A 2005 RAND Corporation study found that NFP families required \$34,000 less in government program expenditures than similar families that did not participate in NFP.⁴² A 2015 study found that when Medicaid pays for NFP services, the federal government saves more on Medicaid expenditures than it spends on NFP.⁴³

In 2010, Maternal, Infant, and Early Childhood Home Visiting (MIECHV) was created as part of the Patient Protection and Affordable Care Act. Overseen by the Health Resources and Services Administration, MIECHV provides funding to state and tribal entities that carry out nurse home visiting services at the state and community levels. In fiscal year 2020, MIECHV entities were providing nurse home visiting services to around 140,000 families.⁴⁴ As seen in the sidebar, evaluation of MIECHV has shown improvement in rates of child abuse, neglect and maltreatment, and school readiness. Families also noted increased economic self-sufficiency and stronger connections to community-based resources.

Currently, MIECHV reaches 30 percent of the nation’s urban counties and 35 percent of the nation’s highest-risk counties, suggesting that there is substantial room for program growth in meeting the needs of disadvantaged women and children.⁴⁶ To increase access, the federal government should increase funding to MIECHV and incentivize states to increase access to MIECHV programs in rural, hard-to-reach, and unserved communities.

Boosting Relationship Education and Fatherhood Skills

Abortion and difficulties with unexpected pregnancies are often the product of broken relationships or relationships that never formed to begin with. In a legal environment that doesn’t allow couples to avoid parenting by choosing abortion, policies should seek to help them learn how to work together for the sake of their children and the society in which these children will one day be parents, community members, and workers. One way to invest in stable families is through the Healthy Marriage and Responsible Fatherhood (HMRF) initiative, a George W. Bush administration program to support community-based programs that provide relationship education services.

Each year, the federal government awards grants: \$150 million to local, nonprofit organizations working to build relationships between couples and help fathers gain the skills they need to be effective parents, dispersed through a competitive grant process.⁴⁷ The program includes rigorous domestic violence and abuse screening to ensure that women are not being encouraged to pursue co-parenting with dangerous partners. A recent Mathematica evaluation of HMRF programs found that couples taking part in relationship education programs were more likely to remain together after a year than were similar couples who didn’t receive healthy relationship services.⁴⁸

Couples in the program also reported higher levels of mutual commitment and, importantly, improved co-parenting behaviors, including reduced levels of destructive behavior between spouses. Domestic violence reports were one-third lower in treatment groups versus control groups.

Mathematica also found that participation in relationship workshops or counseling boosts economic self-sufficiency, financial literacy, and attitudes toward

employment.⁴⁹ Stronger relationship skills were also associated with increases in income, higher employment levels, and lower levels of financial stress.⁵⁰

Expanding access to HMRF programs needs to be a top priority for federal and state governments, especially in areas likely to see an increase in births among disadvantaged women and couples. Congress should consider increasing the resources available through the existing \$150 million federal discretionary grant program, with a priority for low-income communities currently not served by existing grants.

Congress could also take steps to incentivize states to use more of their TANF block grant funds to increase program access. Such incentives might take the form of supplements to existing TANF allocations for states that opt to implement relationship education programs.

Strengthening Child Support Enforcement and Father Employment

Another way state governments can incentivize father involvement both financially and relationally is through improvements to child support and expanded programs to foster employment among noncustodial fathers.

Research shows that regular child support payments reduce child poverty, promote parental responsibility and involvement, and improve children’s educational outcomes.⁵¹ AEI President Robert Doar has written extensively about the need for more fathers to pay child support and the potential benefits that it can bring. His research highlights the need to help fathers gain adequate employment so they can pay child support more consistently.⁵² He has also voiced support for linking certain government benefits, such as nutrition assistance for noncustodial parents, to cooperation with child support enforcement efforts.⁵³

States are also experimenting with ways to involve fathers before childbirth. In 2021, Utah became the first state to mandate that fathers pay child support beginning as soon as pregnancy is determined.⁵⁴ The state mandates that 50 percent of the medical costs during pregnancy are covered by the biological father, including out-of-pocket expenditures, deductibles, and co-pays.

The Utah law demonstrates how to improve financial cost sharing between mothers and fathers while

supporting father engagement. State and local governments are responsible for most child support enforcement programs and administration. The federal government, as the primary funder of the child support enforcement system, has great influence over the development of state strategies and policies.⁵⁵ It can also exercise waiver authority that can support states seeking to develop new and innovative enforcement and father-engagement practices.

In the post-*Roe* environment, the federal government should use its regulatory and waiver authorities to encourage and support experimentation, with a focus on building economic security for mothers and children and trying to ensure fathers' involvement in their children's lives.

Adoption

Another option for women facing unplanned pregnancies is to carry the child to term while they explore placing the baby with adoptive parents. Federal and state government policies on adoption can be strengthened to ensure adoptive parents have the resources they need to navigate a complex and expensive adoption process.

Currently, parents seeking to adopt a child through an agency and privately in the United States face costs between \$25,000 and \$60,000.⁵⁶ Adoption through the foster care system can be nearly free through government reimbursement programs.⁵⁷ Especially for parents who are seeking adoption outside of the foster care system, however, the cost is a significant barrier, especially for younger, less-resourced couples.⁵⁸

While the federal government does not directly fund adoptions in the United States, it does offer tax breaks to parents who adopt children, and it funds adoption assistance, with a focus on encouraging adoption of children with special needs.⁵⁹ Tax breaks for adoption are provided through a tax credit of up to \$14,890 per child.⁶⁰ If parents adopt more than one child in a year, the federal tax credit increases by the number of children being adopted.

Previously, the tax credit applied only to adoption through the foster care system, but it is now applied to all adoptions for families making less than \$223,410 annually. Congress may want to consider increasing the tax credit to reduce barriers for families considering adoption.

Conclusion

Roe v. Wade has been one of the principle drivers of social and political controversy in American life, helping fuel a decades-long public debate on the circumstances under which abortion should be legal. *Dobbs v. Jackson*, by opening the door to greater restrictions on abortion, will likely extend the abortion controversy, albeit in different ways.

While the decision's full effect will not be understood for years, it seems safe to say that as access to abortion declines, the number of unplanned pregnancies that go to term will rise and that these births will be concentrated among disadvantaged families in states that significantly restrict abortion. Many of these states will need federal support to expand and improve pregnancy and child development programs. Even in states that do not decide to restrict abortion, much needs to be done to reduce the burdens that low-income families face during and after unexpected pregnancy.

This is a complex problem that needs thoughtful solutions, requiring states to pay careful attention to how financial subsidies, health programs, and human services initiatives are coordinated so that policies are well integrated and afford the greatest chance of success for women and their children. All levels of government should begin a review of social policies and programs designed to support disadvantaged families and children. They should ask how changes in abortion law might affect need for services targeted to low-income women and children and adjust investments, program structures, and administrative practices accordingly.

In the world of *Dobbs* abortion policy, we are, for a substantial number of disadvantaged women, removing the option for abortion and can therefore expect increases in the number of children who will require public assistance for their maintenance and development. This policy choice will reverberate through families, communities, and all types of public institutions: social services, schools, and health care systems, to name a few. The public, especially conservatives who have worked for decades to overturn *Roe v. Wade*, should put themselves squarely on the side of programs and policies that help ensure every human life is welcomed and protected. Success will depend on an all-of-society effort to translate pro-life rhetoric into reality through efforts that honor the value and dignity of every human life.

About the Author

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