



5-2013

With Liberty and Access for Some: The ACA's Disconnect for Women's Health

Nicole Huberfeld

University of Kentucky College of Law, nicole.huberfeld@uky.edu

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Nicole Huberfeld, *With Liberty and Access for Some: The ACA's Disconnect for Women's Health*, 40 *Fordham Urb. L. J.* 1357 (2013).

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WITH LIBERTY AND ACCESS FOR SOME: THE ACA’S DISCONNECT FOR WOMEN’S HEALTH

*Nicole Huberfeld**

Introduction	1357
I. Historical Anachronisms.....	1362
A. Abortion Is Healthcare	1362
B. The Fragmenting Effect of Stakeholder-Oriented, Rights-Absent Healthcare.....	1365
C. Non Woman-Centric Liberties	1369
II. The Spending Amplification.....	1374
A. A Quick Tour of the ACA.....	1375
B. Public Insurance	1378
C. Private Insurance.....	1382
III. The Impact of <i>NFIB v. Sebelius</i>	1387
Conclusion.....	1392

“And we have now just enshrined, as soon as I sign this bill, the core principle that everybody should have some basic security when it comes to their health care.”¹

INTRODUCTION

If healthcare reform had excluded from its “basic security” cardiac catheterizations, Caesarian section deliveries, or knee replacement surgeries from the services to be covered by either public or private health insurance, the public likely would have been both bewildered

* H. Wendell Cherry Professor of Law, University of Kentucky College of Law and Bioethics Associate, University of Kentucky College of Medicine. Many thanks to the participants in the Medicaid Matters workshop for their insights and encouragement, and to Kathryn Swany for her research assistance. Thanks always DT.

1. President Barack Obama, “*On Behalf of My Mother*,” WHITE HOUSE BLOG (Mar. 23, 2010, 1:33 PM), <http://www.whitehouse.gov/blog/2010/03/23/behalf-my-mother> (signing statement at the signing of the Patient Protection and Affordable Care Act).

and outraged. It would have been bewildered because the goal of healthcare reform was to create near-universal insurance coverage to facilitate equal access to healthcare, and outraged because these procedures are some of the most frequently performed inpatient surgical procedures in the United States.² If access to care was the goal, then covering the procedures most often performed would seem to ensure that various populations receive equitable access to care. Nevertheless, Congress explicitly excluded³ a procedure that current statistics indicate one in three women of childbearing age will need: abortion.⁴ Not even medically necessary abortions, where the fetus is not viable, or where the pregnant woman's health is endangered, are rescued from the pariah designation imposed by the Patient Protection and Affordable Care Act (ACA).⁵

Trading healthcare reform for women's reproductive health was not an unexpected occurrence. In 2010, I predicted that Congress was likely to exclude poor women from the sweeping access to care that the nascent health reform bill appeared poised to provide.⁶ The ACA was an expansive legislative effort that attempted to level the playing field for healthcare access in the United States; in many areas, the ACA is likely to succeed.⁷ But by excluding one of the most common

2. *FastStats: Inpatient Surgery*, CENTERS FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/nchs/fastats/insurg.htm> (last updated May 30, 2013).

3. See Robert Pear, *Negotiating to 60 Votes, Compromise by Compromise*, N.Y. TIMES, Dec. 20, 2009, at A37 (reporting that Senator Harry Reid dropped abortion coverage from the reform bill to appease Senator Ben Nelson, the anti-abortion Democrat from Nebraska).

4. *CDC's Abortion Surveillance System FAQs*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/reproductivehealth/Data_Stats/Abortion.htm (last updated Nov. 21, 2012) (reporting that in 2009, 784,507 legal abortions were reported to the CDC). The Guttmacher Institute reports significantly higher numbers for legal induced abortions (medical and surgical), with the most recent number being over 1.2 million abortions in 2008. *Facts on Induced Abortion in the United States*, GUTTMACHER INST. 1 (Aug. 2011), http://www.guttmacher.org/pubs/fb_induced_abortion.pdf.

5. See Rachel Rebouché & Karen Rothenberg, *Mixed Messages: The Intersection of Prenatal Genetic Testing and Abortion*, 55 HOW. L. J. 983 (2012) (discussing the "collision course" created by the ACA between genetic testing and abortion).

6. See Nicole Huberfeld, *Conditional Spending and Compulsory Maternity*, 2010 U. ILL. L. REV. 751, 783 (noting that Congress was poised to incorporate the Hyde Amendment into healthcare reform legislation).

7. The "ACA" is two separate laws: the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 25, 26, 29 and 42 U.S.C.) and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified as amended in scattered sections of 20, 26, and 42 U.S.C.), which amended multiple

surgical procedures from its sweep, the ACA has traded women's reproductive rights for everyone else's gain in medical care.⁸

Despite this compromise, the ACA contains many provisions that will better women's health by improving their access to consistent care and their status in insurance markets.⁹ Such provisions include the elimination of preexisting condition clauses,¹⁰ prohibitions on rescission,¹¹ open access to obstetric and gynecologic services,¹² required maternity and newborn care,¹³ and the prohibition of lifetime caps on insurance coverage.¹⁴ These private insurance strictures will improve the health of women regardless of their marital, employment, socioeconomic, or other statuses, but especially women of low economic means who historically have had trouble accessing consistent healthcare of any kind.¹⁵ The irony is that these same women are the most likely to suffer unintended pregnancies and to seek abortions to terminate such pregnancies, which neither public nor private insurance will cover under the ACA, except in extremely limited circumstances.¹⁶

titles of Public Law 111-148. This Article refers to the two acts collectively as the ACA, which has become common shorthand for both laws, as they are a functional unit.

8. See Pear, *supra* note 3.

9. See generally Lisa C. Ikemoto, *Abortion, Contraception, and the ACA: The Realignment of Women's Health*, 55 HOW. L. J. 731 (2012) (explaining theoretical approaches to women's health and providing context for separating abortion from other women's health services with a focus on the ACA's "amplification" of this separation); see also *Impact of Health Reform on Women's Access to Coverage and Care*, KAISER FAM. FOUND. (Apr. 2012), <http://www.kff.org/womenshealth/upload/7987-02.pdf>.

10. 42 U.S.C. § 300gg (2012).

11. *Id.* § 300gg-12.

12. *Id.* § 300gg-19a.

13. *Id.* § 18022.

14. *Id.* § 300gg-11.

15. Women in urban areas (and in the South and Southwest) have the highest unintended pregnancy rates. See *National Reproductive Health Profile*, GUTTMACHER INST., <http://www.guttmacher.org/datacenter/profiles/US.jsp> (follow "Pregnancies, Births and Abortions" hyperlink) (last visited July 3, 2013). The reproductive health issues in urban areas are so pressing that the National Institute for Reproductive Health started an initiative dubbed the Urban Initiative for Reproductive Health to focus on the health needs of urban populations. See generally URB. INITIATIVE FOR REPROD. HEALTH, <http://www.urbaninitiative.org/> (last visited July 3, 2013).

16. Section 1303 of the ACA, codified at 42 U.S.C. § 18023, restricts many aspects of funding for abortion. See, e.g., 42 U.S.C. § 18023(a)(1)(A) (private insurers may cover abortion services as part of essential health benefits when they participate as "qualifying health plans" in the insurance exchanges); § 18023(a)(1)(B) (incorporating by reference the Hyde Amendment's prohibition on use of federal

This limitation may be mitigated by the regulatory determination as to which preventive services should be covered free of copayment requirements by insurers.¹⁷ The ACA commands that private insurers must provide coverage of “essential health benefits,” which were to include certain women’s health services,¹⁸ with no required copayment.¹⁹ Working at the Secretary of the Department of Health and Human Services’ behest, the Institute of Medicine (IOM) found that contraception is an essential health benefit, extending the reach of the ACA’s access goals to millions of women for whom contraception was prohibitively expensive.²⁰ Thus, the ACA may significantly expand coverage for, and use of, contraceptives, thereby lowering the number of abortions that women of any background will seek, but especially those for whom rates of abortion have been rising (the poor, African-Americans, and Latinas).²¹ This provision is in jeopardy because secular, private employers have challenged its constitutionality, claiming that the ACA restricts their exercise of religious freedom.²²

Despite the advance in women’s healthcare that the push for covering contraceptives represents, treating women’s medical care as

funding for the Department of Health and Human Services to fund abortions except in cases of threats to the life of the pregnant woman, rape and incest); *id.* § 18023(a)(2)(A) (prohibiting use of federal tax credits for purchase of insurance through exchanges for abortions); *id.* § 18023(a)(2)(B) (prohibiting use of federal funds for abortion by demanding that health plans segregate of personal funds from federal funds such as tax credits for the Exchanges).

17. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule, 78 Fed. Reg. 12834-01 (Feb. 25, 2013).

18. 42 U.S.C. § 18022(b)(4)(C) (requiring that the “health care needs of diverse segments of the population, including women” will be considered in setting the terms of each of the essential health benefits).

19. *Women’s Preventive Services Guidelines*, HEALTH RESOURCES & SERVICES ADMIN., <http://www.hrsa.gov/womensguidelines/> (last visited July 1, 2013).

20. INST. OF MED. OF THE NAT’L ACADS., *CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 109–16* (2011), available at http://books.nap.edu/openbook.php?record_id=13181.

21. *Unintended Pregnancy Prevention*, CENTERS FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/index.htm> (last updated Feb. 12, 2013) (citing statistics regarding disparities in unintended pregnancy rates and abortion rates).

22. See *Hobby Lobby Stores, Inc. v. Sebelius*, No. 12–6294, 2013 WL 3216103 (10th Cir. June 27, 2013); see also Caroline Mala Corbin, *The Contraception Mandate*, 107 NW. U. L. REV. COLLOQUY 151 (2012) (providing a succinct explanation of the issues related to this First Amendment litigation, and explaining why the so-called contraception mandate is not a violation of anyone’s First Amendment rights).

a political trading card diminishes the status of women in the polity and has retrograde ramifications for their health. Abortion is a medical procedure, but the political rhetoric of “choice” versus “life” seems to have co-opted the hard fact that women sometimes need abortions for medical reasons, and prohibiting access to abortions, even by the indirect method of funding, ultimately can endanger women’s lives.²³ This is especially true for the low-income women who rely on Medicaid²⁴ or who will receive the tax subsidies available for purchasing private insurance in the exchanges (a line that will undoubtedly be fluid).²⁵ The great paradox of the ACA is that it creates substantial new obstacles to reproductive health at the same moment that it attempts to improve access for women’s healthcare.

This Article will scrutinize the separation of abortion from other aspects of women’s health through the vehicle of the ACA. Part I will examine briefly why the fragmented nature of American healthcare has facilitated the separation of abortion from women’s health, despite the fact that abortion is a medically necessary procedure for many women. To that end, this Part will explore the disjointed history of access to medicine juxtaposed against the strangely non-woman-centric nature of the fundamental rights at play in reproductive health. Part II will provide an overview of the ACA to explain the spending elements of the ACA that magnify greatly the limits on access to abortion in both public and private health insurance programs. Part III will summarize the jurisprudential changes resulting from *National Federation of Independent Business v. Sebelius*²⁶ and analyze three ways in which *NFIB* affects women’s health under the ACA.

23. See B. Jessie Hill, *What Is The Meaning of Health? Constitutional Implications of Defining “Medical Necessity” and “Essential Health Benefits” Under the Affordable Care Act*, 38 AM. J.L. & MED. 445 (2012) (discussing the difficulty of grounding this problem in constitutional arguments).

24. Some women are already covered by Medicaid by virtue of being pregnant or being parents. See 42 U.S.C. § 1396a(a)(10)(A) (2012). For childless women, Medicaid coverage will be available in states that opt in to the ACA’s expansion of Medicaid as of January 1, 2014. 42 U.S.C. § 1396a; see also Rachel Benson Gold, *Insurance Coverage and Abortion Incidence: Information and Misinformation*, 13 GUTTMACHER POL’Y REV. 4, 9 (2010) (explaining how the expansion of the Hyde Amendment will affect Medicaid enrollees and especially enrollees in states that prohibit use of state funds for abortion services).

25. 26 U.S.C. § 36B.

26. 132 S. Ct. 2566 (2012).

I. HISTORICAL ANACHRONISMS

The ACA's reliance on existing fractured finance and delivery systems facilitated the separation of reproductive care from the remainder of the law. This Part will consider the role of historical paths in American healthcare to contextualize how healthcare reform could exclude a commonly performed, non-experimental medical procedure from its otherwise patient-protective approach to healthcare access. It will then review the underlying rights that should protect women from the ACA's segregation of reproductive care. Studying these structural elements of American healthcare helps to clarify how pre-existing systemic deficiencies facilitated the amplification of the Hyde Amendment, which will be explored in Part II.

A. Abortion Is Healthcare

Women's sexual health is a beacon for political controversy, and the ACA has been no exception. Therefore, it is important to highlight this fact: abortion is a form of medical care for women.²⁷ Pregnancies may be terminated either surgically or by oral medication; both situations require medically trained personnel.²⁸ The medical assistance necessary for abortion both helps to define it as healthcare for women and increases the complexity of its regulation, as healthcare providers are licensed by each state in which they provide medical services and are subject to the special rules that often attend abortion.²⁹ Abortion may be performed for a number of

27. The 2012 election cycle made this abundantly clear, with federal congressional and presidential candidates making statements that abortion was never necessary to save the life of a pregnant woman. See, e.g., Liz Goodwin, *Congressman Says Abortions Never Necessary to Save Life of Mother*, YAHOO! NEWS (Oct. 19, 2012), <http://news.yahoo.com/blogs/ticket/congressman-says-abortions-never-necessary-save-life-mother-175130900--election.html>. Doctors swiftly responded to clarify that such statements were political, not medical, and that abortion is often medically required to protect women's health. *Response to Politicians' Inaccurate Abortion Comments*, AM. CONGRESS OBSTETRICIANS & GYNECOLOGISTS (Oct. 19, 2012), http://www.acog.org/About_ACOG/News_Room/News_Releases/2012/Response_to_Politicians_Inaccurate_Abortion_Comments. For example, ectopic pregnancies occur "in 1 in every 40 to 1 in every 100 pregnancies," arguably threaten the life of a pregnant woman, and would be covered by Medicaid. *Ectopic Pregnancy*, MEDLINE PLUS, <http://www.nlm.nih.gov/medlineplus/ency/article/000895.htm> (last updated Mar. 22, 2013).

28. Carol Sanger, *About Abortion: The Complications of the Category*, 54 ARIZ. L. REV. 849, 852 (2012) (describing the medical nature of abortion).

29. Many of the restrictions on abortion were made possible by the decision in *Casey*, discussed further below. See *infra* note 64 and accompanying text.

medical reasons, such as ectopic pregnancy, fetal abnormality, life- and health-threatening pregnancy-related complications (such as blood clots), or incomplete spontaneous miscarriage.³⁰ This recognition was a foundational element of the initial push for decriminalizing abortion in the 1960s, which came not only from women's rights organizations but also from the medical profession.³¹ Over time, the narrative of women's medical need for abortion has been lost both in the law and in the public conversation.³² But the fact that abortion is a medical procedure, and thus part of the constellation of women's healthcare, remains.

Abortion's medical status is reflected in widespread private insurance coverage of abortion, relevant here because of the changes that the ACA has wrought. Prior to the ACA, an estimated eighty-seven percent of private insurance plans covered abortion.³³ This coverage is consistent with insurers' predilection for covering non-experimental, medically necessary procedures.³⁴ Though Medicaid generally follows the same pattern, it long has been subject to political pressures that alter its otherwise comprehensive coverage of medically necessary care.³⁵ Thus, as will be discussed further below, Medicaid long has restricted federal funds from being directed to abortion services.³⁶ This coverage disparity contributes to the ever-

30. See, e.g., Andreea A. Creanga et al., *Trends in Ectopic Pregnancy Mortality in the United States: 1980–2007*, 117 *OBSTETRICS & GYNECOLOGY* 837, 837 (2011). The vast majority of late-term abortions are performed for medical reasons. See Brief of the American College of Obstetricians & Gynecologists as Amicus Curiae Supporting Respondents at 10–15, *Gonzales v. Carhart*, 550 U.S. 124 (2007) (Nos. 05-380, 1382), 2006 WL 2867888 at *17–29.

31. See Reva B. Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 *STAN. L. REV.* 261, 273–75 (1992) (describing *Roe's* grounding in the therapeutic concept of abortion).

32. See Steven E. Weinberger et al., *Legislative Interference with the Patient-Physician Relationship*, 367 *NEW ENG. J. MED.* 1557 (2012) (reminding politicians that medical care does not benefit from political, non-scientific intervention); see also Yvonne Lindgren, *The Rhetoric of Choice: Restoring Healthcare to the Abortion Right*, 64 *HASTINGS L.J.* 385, 391–93 (2013) (describing the roots of the abortion movement in the “therapeutic” need for doctors to provide abortions to women).

33. The data is slightly out of date, but it has not been updated. See Adam Sonfield et al., *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates, 2002*, 36 *PERSP. ON SEXUAL & REPRODUCTIVE HEALTH* 72, 76 (2004).

34. Mark A. Hall & Gerald F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 *U. PA. L. REV.* 1637 (1992) (discussing health insurers' role in assessing which medical procedures are appropriate for payment and thus appropriate for treatment).

35. See *infra* notes 113–39 and accompanying text.

36. See *infra* notes 113–39 and accompanying text.

widening gap in care between poor women and women with financial resources.

The federal Medicaid payment restriction has pushed many state courts to consider the place of abortion under state constitutions. Thus, thirteen states have recognized, as a matter of state constitutional law, that abortion is a medically necessary procedure requiring funding for poor women.³⁷ Presented with challenges to restrictions on Medicaid funding of abortions, the courts generally have held that poor women cannot be forced to suffer health-jeopardizing pregnancies by virtue of the state's interest in life.³⁸

37. *State Funding of Abortion Under Medicaid*, GUTTMACHER INST., http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf (last updated July 1, 2013).

38. *See, e.g.,* *Right to Choose v. Byrne*, 450 A.2d 925 (N.J. 1982) (holding that the New Jersey state constitution protected poor women's funding of abortion for "medically necessary" abortions). The court wrote:

[T]here [is no] fundamental right to funding for an abortion. The right to choose whether to have an abortion, however, is a fundamental right of all pregnant women, including those entitled to Medicaid reimbursement for necessary medical treatment. As to that group of women, the challenged statute discriminates between those for whom medical care is necessary for childbirth and those for whom an abortion is medically necessary. Under [the statute] those needing abortions receive funds only when their lives are at stake. By granting funds when life is at risk, but withholding them when health is endangered, the statute denies equal protection to those women entitled to necessary medical services under Medicaid.

Id. at 934. The court continued,

Although that is a legitimate state interest, at no point in a pregnancy may it outweigh the superior interest in the life and health of the mother. Yet the funding restriction gives priority to potential life at the expense of maternal health. From a different perspective, the statute deprives indigent women "of a governmental benefit for which they are otherwise eligible, solely because they have attempted to exercise a constitutional right."

Id. at 935 (citation omitted); *see also* *Simat Corp. v. Ariz. Health Care Cost Containment Sys.*, 56 P.3d 28 (Ariz. 2002). The *Simat* court wrote:

Refusing abortions and thus preventing administration of the needed therapy for seriously ill women may promote childbirth and protect the fetus, but in some cases it will undoubtedly destroy the health and perhaps eventually the life of the mother. In such a situation, the state is not simply influencing a woman's choice but actually conferring the privilege of treatment on one class and withholding it from another. . . . Surely, a woman's right to choose preservation and protection of her health, and therefore, in many cases, her life, is at least as compelling as the state's interest in promoting childbirth. The restrictions in the [Medicaid] funding scheme thus not only endanger the health of women being treated in their program but prevent those women from choosing a medical procedure, abortion, when necessary to preserve their health. . . . given the right of choice announced in *Roe*, once the state allows abortion funding if immediately necessary to save the mother's life, the state's interest in

These decisions often emphasize the medical nature of abortion that underlies the impermissible distinctions being drawn for poor women in Medicaid.³⁹

This is not to say that the medical nature of abortion should leave the decision to have an abortion in a doctor's hands, or that health plan coverage of abortion should be limited to so-called "therapeutic" abortions. Instead, the medical aspect of abortion highlights the disconnect between the proclaimed goal of providing "basic security" for healthcare and the reality of the ACA treating abortion as if it were not a form of healthcare.

B. The Fragmenting Effect of Stakeholder-Oriented, Rights-Absent Healthcare

America's medical system developed in a piecemeal fashion that was often more attuned to its stakeholders than to the medical needs of patients. This patchwork has been described as "fragmented" or "disintegrated."⁴⁰ Physicians arguably have dominated the discourse by developing their medical profession into a guild that protected itself and its political interests, often at the expense of patients and the development of a coherent healthcare system.⁴¹ Every time politicians or other actors have pushed for developments such as universal health insurance, or advances in public health, or the alignment of stakeholder interests through vehicles such as integrated

promoting childbirth cannot be considered sufficiently compelling to justify refusing to protect the health of a seriously ill woman. . . . Thus, we conclude that the laws and regulations in question violate the provisions of article II, § 13 of the Arizona Constitution, which prohibit the enactment of any law granting any citizen privileges that shall not on the same terms "equally belong to all citizens."

Simat, 56 P.3d at 34.

39. See Linda J. Wharton, *Roe at Thirty-Six and Beyond: Enhancing Protection for Abortion Rights Through State Constitutions*, 15 WM. & MARY J. WOMEN & L. 469, 500–10 (2009) (discussing the themes of the state courts' decisions regarding payment for poor women's abortions).

40. See generally THE FRAGMENTATION OF U.S. HEALTH CARE (Einer Elhague ed., 2010) (collection of essays describing America's "fragmented" healthcare system and prescribing changes to eliminate fragmentation, which the opening essay loosely defined as "unified decision making"). Professor Elhague chose the term "fragmented" to describe the disunity of the American healthcare system because he sees integration and disintegration as descriptors, not necessarily fraught with negative connotation, where as "fragmentation" has normatively negative implications. See *id.* at 2 n.I.

41. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 2–29 (1982) (introducing and summarizing the book's premise that physicians have driven the format of American medicine socially and politically).

delivery systems, physicians have resisted, very successfully, by claiming that their autonomy would be jeopardized by any unitary reform to healthcare delivery.⁴² Hospitals have also defended their territory, as have other healthcare industry stakeholders who fear losing their piece of the pie.⁴³

One way to explain stakeholders' success in fending off a philosophically, legally, or pragmatically cogent healthcare system is that no constitutional right to healthcare exists in the United States.⁴⁴ Some scholars have argued for such a right through, for example, a conception of property rights⁴⁵ or through state constitutions,⁴⁶ but the consensus is that no individual right to healthcare exists in the text or interstices of the United States Constitution.⁴⁷ This is not to say that a right to healthcare could not be read into certain clauses or amendments to the Constitution, but no Supreme Court case has ever

42. See Einer Elhauge, *Why We Should Care About Healthcare Fragmentation*, in *THE FRAGMENTATION OF U.S. HEALTH CARE* 1, 12 (Einer Elhauge ed., 2010) (describing law as the source of healthcare fragmentation in the United States, laws that were "at least partly motivated by the interest group power of physicians"); see also STARR, *supra* note 41, at 235–89 (describing physicians' role in preventing a uniform health insurance system in the United States and staving off other forms of interest alignment in the American healthcare delivery system). It is hard to say in the case of the ACA whether physicians "won." The tradition of deference to physicians was overridden by political maneuvering, as the AMA opposed the law and it still passed; and, the American College of Obstetricians and Gynecologists supported access to all kinds of healthcare for women, including abortion, but abortion has been excluded from the long list of women's health services that must be covered by the ACA.

43. See STARR, *supra* note 41, at 295–310 (discussing hospitals' resistance to health insurance and their lobbying efforts to prevent any form of management or control over their medical autonomy).

44. The exception to this rule is prisoners, for whom it is an Eighth Amendment violation (cruel and unusual punishment) to withhold medical care. See *Estelle v. Gamble*, 429 U.S. 97, 103–04 (1976) ("These elementary principles establish the government's obligation to provide medical care for those whom it is punishing by incarceration. . . . We therefore conclude that deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain'" (citation omitted)).

45. See, e.g., Mark Earnest & Dayna Bowen Matthew, *A Property Right to Medical Care*, 29 J. LEGAL MED. 65 (2008) (arguing that "Americans have a property right to receive medical care").

46. See generally Elizabeth Weeks Leonard, *State Constitutionalism and the Right to Health Care*, 12 U. PA. J. CONST. L. 1325 (2010) (recognizing the lack of a federal constitutional right to healthcare and cataloging the various state constitutional rights to medical care).

47. See, e.g., TIMOTHY STOLTZFUS JOST, *DISSENTLEMENT?* 25 (2003) ("[N]owhere in the Constitution is there a hint of a right to health care.").

held that a collective or individual right to healthcare exists.⁴⁸ Though in the modern era this absence might seem like a gross oversight, medicine leaned toward barbarism in the late 1700s, and a right to healthcare would have meant a right to bloodletting and other dubious practices.⁴⁹

In addition, at common law, physicians did not have a duty to treat anyone they did not wish to, unless an existing physician-patient relationship created an ongoing duty of care.⁵⁰ One could argue that federal statutes such as Medicare,⁵¹ Medicaid,⁵² and the Emergency Medical Treatment and Labor Act⁵³ create statutory “rights” to healthcare, but these are not coherent rights that extend to all citizens. Though these statutes fill some gaps, they do not cover enough ground to describe a general right to healthcare. Stakeholders arguably have had no drive to create a cogent medical

48. *But see* George J. Annas, *A Poor Read on Rights, Rationing, and Racism*, 32 HEALTH AFF. 627 (2013), available at <http://content.healthaffairs.org/content/32/3/627.full.pdf+html>. Refuting the reviewed book’s assertions about healthcare rationing and rights, Professor Annas asserts a broad-based view of healthcare “rights”:

The United States does, nonetheless, have all kinds of health care rights: constitutional rights; statutory rights, which are sometimes called entitlements; and common-law rights. The only Americans who have a constitutional right to health care are prisoners under the Eighth Amendment. . . . Women in the United States have a constitutional right to birth control and abortion, although not to have them financed. Among the major statutory entitlements are Medicare; Medicaid; and medical services for veterans, active-duty military personnel, and Native Americans. The most important common-law right to health care is the right to treatment in a hospital emergency department (at least until one’s condition is stabilized), assuming one can get to the emergency department and is assessed as having an emergency condition. This right is also a federal statutory right because of the Emergency Medical Treatment and Active Labor Act of 1986. These are all rights regarding access to health care. There are also a whole set of rights that individual patients have, sometimes referred to as “patients’ rights,” once they are under care, including informed consent, confidentiality, and privacy. And, in this land of liberty, perhaps the strongest right in health care, and one that is also a constitutional right, is the right to refuse treatment.

Id.

49. *See* STARR, *supra* note 41, at 155–57 (explaining the advent of hygienic hospital practices and antiseptic surgery followed by aseptic surgery shortly thereafter).

50. *See, e.g.*, *Ricks v. Budge*, 64 P.2d 208 (Utah 1937) (holding that doctors have no duty to treat unless an existing physician-patient relationship creates such an obligation).

51. 42 U.S.C. § 1395 (2012).

52. 42 U.S.C. § 1396.

53. 42 U.S.C. § 1395dd.

system—neither common law nor constitutional law would have forced them to do so—and only recently have states attempted bold systemic reforms.⁵⁴

A constitutional right to medical care would not automatically lead to coherent healthcare delivery or aligned healthcare provider interests.⁵⁵ Certain kinds of patients or procedures, however, can be separated more easily from the protection of the herd if patients have no recourse in the Constitution, statutes, or common law. Arguably, the lack of a right to healthcare has smoothed the path to segregating one particular medical procedure from the attempt to create a plenary healthcare coverage scheme. The strange irony of segregating abortion is that women do have a protected right to access abortion by virtue of *Roe v. Wade*,⁵⁶ but that right has been limited over time. Further, the right is theoretical if the care itself is inaccessible, which is especially true for poor women who do not have the resources to pay for private care.⁵⁷

Another aspect of the fragmented healthcare system that facilitates the separation of one procedure from the treatment of the whole person is the partition of the poor in public insurance (Medicaid) from forms of private insurance that historically have been subject to little government intervention.⁵⁸ In the next Part, this Article will discuss the ramifications of abortion restrictions in both public and private insurance; here, the point is structural rather than substantive. Divided mechanisms of insurance further fragment healthcare and make it easier to chip away at certain patients' coverage. Medicaid enrollees in particular have been targeted for legislators' morality

54. An obvious example is Massachusetts, which created universal insurance coverage in 2006 with "MassCare," the model for the ACA. See 2006 Mass. Acts 58 (session law creating universal insurance coverage).

55. The Universal Declaration of Human Rights, a document created by the United Nations in the aftermath of World War II, contains an aspirational "right" to healthcare in Article 25, which provides: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services . . ." Universal Declaration of Human Rights, G.A. Res. 217(III)A, U.N. Doc. A/Res/217(III) (Dec. 10, 1948). The United States has never adopted this Declaration. And even countries that have adopted it do not necessarily have cohesive healthcare access or delivery.

56. 410 U.S. 113 (1973).

57. All Medicaid enrollees are impoverished and thus unable to pay for private healthcare. The purpose of the Medicaid Act is to help to mainstream our low-income citizens into the healthcare system. See 42 U.S.C. § 1396a(a)(10) (describing categorical and financial eligibility for Medicaid enrollees).

58. 42 U.S.C. §§ 1396 to 1396w-2.

plays: one classic example was Representative Henry Hyde, who wanted to prevent all abortions.⁵⁹ Representative Hyde knew he only had power over the poor women who relied on Medicaid for their access to healthcare services.⁶⁰ Thus, he attached a rider on the Department of Health and Human Services' (HHS) annual budget that still prevents Medicaid payment for abortion except in extremely limited circumstances (such as rape, incest, and life endangerment).⁶¹ Despite the protected right in *Roe v. Wade*, poor women could not stop Congress or the Court from defunding abortion.⁶²

Poor women have no protection from medical segregation. They do not have a right to healthcare, they do not participate in a program that most voters contemplate or participate in, and they do not otherwise have political influence.⁶³ The question that remains is how the abortion procedure, which is supposed to be protected by the fundamental right to privacy, can be excluded from the otherwise universal push for access to healthcare that the ACA embodies.

C. Non-Woman-Centric Liberties

The legal precedents undergirding the privacy right that protects access to abortion generally do not protect women as members of the polity or as patients.⁶⁴ The failure to recognize the privacy and other

59. 123 CONG. REC. 19,700 (1977) (statement of Rep. Hyde).

60. *See id.*

61. *Id.*

62. *See infra* notes 66–85 and accompanying text.

63. *See, e.g.,* Singleton v. Wulff, 428 U.S. 106 (1976) (permitting third party standing for doctors who treat Medicaid patients because, among other reasons, Medicaid patients face insurmountable obstacles to getting into federal court, such as poverty).

64. Justice Ginsburg acknowledged this shaky foundation for women's access to abortion in her scathing dissent in *Gonzales v. Carhart*, the 2007 decision that upheld the federal Partial Birth Abortion Ban Act. *See* *Gonzales v. Carhart*, 550 U.S. 124, 169 (2007) (Ginsburg, J., dissenting). Justice Ginsburg documented the majority's departure from *Roe* and *Casey* while at the same time noting the weakness of those precedents in failing to recognize control over reproductive health as a matter of equal protection. She wrote:

As *Casey* comprehended, at stake in cases challenging abortion restrictions is a woman's "control over her [own] destiny." "There was a time, not so long ago," when women were "regarded as the center of home and family life, with attendant special responsibilities that precluded full and independent legal status under the Constitution." Those views, this Court made clear in *Casey*, "are no longer consistent with our understanding of the family, the individual, or the Constitution." Women, it is now acknowledged, have the talent, capacity, and right "to participate equally in the economic and social life of the Nation." Their ability to realize their full

rights that protect women's health as being central to women's rights has facilitated fragmentation in women's healthcare.⁶⁵ This is a structural theory regarding the segregation of abortion from the rest of women's health, rather than a substantive argument about the underlying doctrine's disconnect from women's rights, and this framework has facilitated the greatest obstacle to women's access to abortion since *Harris v. McRae* was decided.

Harris v. McRae is the direct progenitor of the ACA's abortion restrictions because it upheld the Hyde Amendment's restriction on federal funding for abortion.⁶⁶ The Court reasoned that Congress did not create the obstacle⁶⁷ to abortion access because the women enrolled in Medicaid were impoverished by their own fault, rather than the fault of the government.⁶⁸ The federal government,

potential, the Court recognized, is intimately connected to "their ability to control their reproductive lives." *Thus, legal challenges to undue restrictions on abortion procedures do not seek to vindicate some generalized notion of privacy; rather, they center on a woman's autonomy to determine her life's course, and thus to enjoy equal citizenship stature.*

Id. at 171–72 (citations omitted) (emphasis added). In so reasoning, Justice Ginsburg cited some of the most important work on reproductive rights as matters of equality, which served to underscore her critique of the substantive due process basis for *Roe* and *Casey's* privacy right. *See id.* at 172 (citing Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261 (1992); Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955 (1984)).

65. *See generally* Yvonne Lindgren, *The Rhetoric of Choice: Restoring Healthcare to the Abortion Right*, 64 HASTINGS L.J. 385 (2013) (describing how *Roe's* contextualization of abortion in the medical relationship was useful for perceiving abortion as part of healthcare and arguing that abortion must be positioned within a conception of women's health that the Court has not recognized recently).

66. *Harris v. McRae*, 448 U.S. 297 (1980).

67. *Id.* at 315 ("The Hyde Amendment . . . places no governmental obstacle in the path of a woman who chooses to terminate her pregnancy, but rather, by means of unequal subsidization of abortion and other medical services, encourages alternative activity deemed in the public interest.").

68. *Id.* at 316–17. The key passage from *Harris* is as follows:

But, regardless of whether the freedom of a woman to choose to terminate her pregnancy for health reasons lies at the core or the periphery of the due process liberty recognized in *Wade*, it simply does not follow that a woman's freedom of choice carries with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices. The reason why was explained in *Maher*: although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation. Indigency falls in the latter category. The financial constraints that restrict an indigent woman's ability to enjoy the full range of constitutionally protected freedom of choice are the product not of governmental restrictions on access to abortions, but rather

therefore, did not improperly restrict access to abortion by refusing to fund it, despite the unambiguous, targeted testimony that the Hyde Amendment was designed to prevent poor women from accessing abortion.⁶⁹ The Court rejected an individual liberty argument, an equal protection argument, and a rationality argument that the Hyde Amendment infringed the rights of poor women and that the federal government was not asserting a legitimate interest in restricting access to abortion.⁷⁰ It is possible that the *Harris* majority saw this funding restriction as a small carve-out or a minor funding issue.⁷¹ But if the Court had held that the Hyde Amendment was not a permissible restriction on abortion, the ACA would look very different. This federal funding limitation for the small population of women enrolled in Medicaid in 1980 has become a channel by which, thirty years later, the ACA restricted funding for both private and public insurance coverage of abortion without fear of infringing women's constitutional rights.

Harris v. McRae sprang from more prominent liberty-protecting precedent—specifically, the line of Supreme Court decisions discovering individual fundamental rights that facilitated the Court's holding in *Roe v. Wade*.⁷² None of this precedent, however, focused on women as the protected party per se. For example, in 1942, the Court held that the right to procreate was fundamental to the human condition and was protected by the Fourteenth Amendment, but the context for the decision was freedom from unwanted sterilization for

of the woman's indigency. Although Congress has opted to subsidize medically necessary services generally, but not certain medically necessary abortions, the fact remains that the Hyde Amendment leaves an indigent woman with at least the same range of choices in deciding whether to obtain a medically necessary abortion as she would have had if Congress had chosen to subsidize no health care costs at all. We are thus not persuaded that the Hyde Amendment impinges on the constitutionally protected freedom of choice recognized in *Wade*.

Id.

69. Representative Hyde stated during the floor debate of the so-called Hyde Amendment: "I certainly would like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available is the HEW medicaid [sic] bill." 123 CONG. REC. 19,700 (1977) (statement of Rep. Hyde).

70. *Harris*, 448 U.S. at 324–26.

71. Elsewhere, I evaluated the struthious analysis in *Harris* as a function of the "negative versus positive rights" analysis of constitutional rights as well as a function of the "greater includes the lesser" theory of congressional power. Huberfeld, *supra* note 6, at 756–67.

72. 410 U.S. 113 (1973).

prisoners, not a positive right to procreate.⁷³ In 1965, the Court held in *Griswold v. Connecticut* that married couples had a right to privacy in the marital bedroom that encompassed using contraceptives in that private space.⁷⁴ This decision arguably resulted from a push by physicians to treat patients as they saw fit; thus, this holding focused on the physician-patient relationship rather than women as autonomous patients.⁷⁵ In 1972, the Court held in *Eisenstadt v. Baird* that unmarried people had a right to be free from criminal prosecution for purchasing and using contraceptives.⁷⁶ This decision hinged on the Equal Protection Clause and the determination that states could not legitimately distinguish between married and unmarried users of contraception.⁷⁷ Again, the context was not reproductive justice for women. Finally, after being argued in 1971, the Court issued a physician-centric decision in 1973 in *Roe v. Wade*, which held that a right to privacy encompassed the decision to end a pregnancy.⁷⁸ *Geduldig v. Aiello*, decided in 1974, underscored these opinions when it infamously held that exclusion based on pregnancy is not sex-based discrimination.⁷⁹

Although these decisions protected women from governmental barriers in their healthcare lives, women qua women are absent from the Court's analyses. These foundational decisions did not articulate baseline protections for women as patients making autonomous decisions, or as members of the citizenry, or as equal political and economic participants in society. Undoubtedly, Congress has detected leeway to impose substantial obstacles to women's access to

73. *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942).

74. 381 U.S. 479 (1965).

75. See Reva B. Siegel, *Roe's Roots: The Women's Rights Claims That Engendered Roe*, 90 B.U. L. REV. 1875, 1884 (2010) (explaining the physicians' right to treat basis for some early abortion cases, including *Griswold*).

76. 405 U.S. 438 (1972).

77. *Id.* at 453–54.

78. 410 U.S. 113 (1973). As Linda Greenhouse noted, the Court mentioned the word "physician" more often than the word "woman" in the *Roe* opinion. Linda Greenhouse, *Misconceptions*, N.Y. TIMES OPINIONATOR (Jan. 23, 2013, 9:00 PM), <http://opinionator.blogs.nytimes.com/2013/01/23/misconceptions/> (highlighting, on the fortieth anniversary of the decision, that women barely appeared in the language or reasoning of *Roe v. Wade*).

79. 417 U.S. 484 (1974) (holding that California did not impermissibly discriminate based on sex by excluding disability due to pregnancy from a state disability fund). As Professor Law has noted, this concept is laughable, but it is very much of a piece with the Court's inability to incorporate women's rights into decisions that arguably protect women. Law, *supra* note 64, at 983 (chronicling critiques of *Geduldig*).

abortion.⁸⁰ Historically, congressional flouting of the privacy right has existed primarily in Medicaid, though it has extended to other, smaller programs that enjoy federal funding through either outright prohibitions on funding abortions, such as for women in the military, or through conscience clause protections that protect healthcare providers participating in programs that receive federal funding.⁸¹ In 2010, I dubbed these restrictions “pure funding statutes” and “conscience clause funding statutes.”⁸² The ACA promotes a much greater reach for abortion obstacles by amplifying both pure funding and conscience clause funding laws.⁸³

The concatenated nature of the fundamental rights protecting women’s access to abortion, in conjunction with the holding in *Harris v. McRae*, has facilitated a fracturing of women’s health needs.⁸⁴ The ACA divides contraception from abortion in a manner made possible by a constitutional framework that lacks coherent vectors. Both the right to use contraception and the right to access abortion hinge on a constitutional concept of privacy protection, yet the ACA seems to legitimize only one—contraception—which has been subject to less litigation but is rooted in the same jurisprudence. If anything, the abortion right should be more clearly about women’s equal status in society given the feminist movement that had gained momentum through litigating state abortion bans by the time *Roe* was decided.⁸⁵

The Obama administration appears prepared to make President Clinton’s famous “safe, legal, and rare” remark about abortion into a

80. *But see generally* Siegel, *supra* note 75 (examining the feminist claims to abortion rights immediately predating the decision in *Roe* and explaining how the feminist movement influenced the Court’s 7-2 decision in *Roe*).

81. *See* Huberfeld, *supra* note 6, at 767–81 (discussing two kinds of federal spending statutes: those that refuse to cover abortion, and those that permit healthcare providers to recuse themselves from providing abortions, sterilizations, and other reproductive care services).

82. *See id.* at 767 (creating the terms described).

83. Pub. L. 111-148 §§ 1303, 10104 (codified at 42 U.S.C. § 18023) (prohibiting payment for abortions with federal funds, requiring segregated private payment for abortion coverage in health insurance plans in the Exchanges, and enhancing “provider conscience protections”).

84. Studies have shown that greater levels of unintended pregnancy are linked with higher incidence of abortion. Thus, the argument that women’s access to abortion should be protected by the ACA is not an argument that necessarily leads to more abortion, just safer, earlier abortion in less stressful circumstances. *See, e.g.,* Rachel Benson Gold, *Insurance Coverage and Abortion Incidence: Information and Misinformation*, 13 GUTTMACHER POL’Y REV. 4 (2010).

85. *See* Siegel, *supra* note 75, at 1888–96 (tracing the strategies employed by women’s rights groups to change the focus from doctors’ rights to women’s rights).

reality. Pregnancy is a surprise to half of American women who learn they are pregnant, and almost forty percent of those surprise pregnancies end in abortion.⁸⁶ Fewer surprise pregnancies by virtue of greater contraception access surely must mean that fewer women will seek abortion.⁸⁷ But this hope does not protect those women who will still need to access safe, legal abortions for whatever reason, regardless of their income status. A fragmented system and a fractured right have made way for the federal government to exclude one common form of healthcare from all others. No matter how much access is gained through the ACA, poor women and women of color will suffer from this federal push to delegitimize abortion access. Historically, the segregation of abortion has existed primarily in the world of public insurance, but as of 2014, women in both public and private insurance plans will be subject to restrictions on funding of abortion.

II. THE SPENDING AMPLIFICATION

The ACA restricts abortion access by placing limitations on federal funding for any abortion except those resulting from life endangerment for the pregnant woman, rape, or incest.⁸⁸ Such financial constraints are bound to affect poor women more dramatically than women of means because they will rely on either Medicaid or federal tax credits to obtain health insurance coverage, thereby inextricably linking poor women to limits on abortion.⁸⁹ Though at first glance it could appear that the application of the Hyde Amendment to all forms of insurance would not be much different from its longstanding application to Medicaid, the ACA undoubtedly aggrandizes the Hyde Amendment. The following discussion demonstrates the greater limitations on abortion access initiated by the ACA for both public and private insurance, at both the federal and the state level.

86. *Facts on Induced Abortion in the United States*, GUTTMACHER INST. 1 (Aug. 2011), http://www.guttmacher.org/pubs/fb_induced_abortion.pdf.

87. Gold, *supra* note 84, at 10.

88. Pub. L. 111-148 § 1303(a)(1)(B)(i) (codified at 42 U.S.C. § 18023(a)(1)(B)(i)) (incorporating by reference the Hyde Amendment, which contains the exception described).

89. *See infra* notes 98, 109 and accompanying text. Medicaid will cover all adults under age 65 up to 133% of the federal poverty level, and those earning 100–400% of the federal poverty level will receive tax credits for purchasing private health insurance in Exchanges. *Id.*

A. A Quick Tour of the ACA

Despite its ambitious goals, the ACA is not a radical law. It builds on the existing medical system without shaping American healthcare into a more philosophically coherent, less fragmented system.⁹⁰ The ACA's crown jewel is arguably that it facilitates a health insurance home for all Americans.⁹¹ The ACA encourages all people legally residing in the United States to obtain health insurance coverage by requiring most people to pay a tax penalty for lack of coverage effective as of tax year 2014.⁹² The law allows various methods of compliance with the individual mandate through private health insurance (employer-based, small group, individual) or public health insurance (Medicare, Medicaid, veterans' benefits, federal employee benefits) and permits limited exceptions for people with religious objections (such as Christian Scientists).⁹³ An estimated thirty million new lives will be covered by virtue of the ACA's insurance reform implementation.⁹⁴

In 2011, about fifty-five percent of Americans had access to health insurance through their employer.⁹⁵ Those who do not have access to private health insurance through their employer will be eligible to purchase private health insurance through health benefit exchanges ("Exchanges"), which will act as clearinghouses for qualified health insurance plans to sell small group and individual insurance products.⁹⁶ Exchanges can be run either by the state, by the federal

90. PAUL STARR, *REMEDY AND REACTION* 23 (2011) (describing how this round of healthcare reform negotiations resulted in building on the existing private/public insurance framework).

91. The first two titles of the ACA as a public law are focused on modifications to private insurance and public insurance to facilitate access to healthcare, which in the United States occurs by having health insurance. Pub. L. 111-148, Title I (Quality, Affordable Health Care for All Americans) & II (Role of Public Programs).

92. Pub. L. 111-148 § 1501 (codified at 42 U.S.C. § 18091 and 26 U.S.C. § 5000A). This requirement (the "individual mandate") was upheld as a permissible exercise of Congress's tax power on June 28, 2012, in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012).

93. Pub. L. 111-148 § 1501 (codified at 26 U.S.C. § 5000A(d)).

94. CONG. BUDGET OFFICE, *UPDATED ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT* 3 (2012), available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf>.

95. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, *INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2011*, at 21 (2012), available at <http://www.census.gov/prod/2012pubs/p60-243.pdf>.

96. Pub. L. 111-148 Title I, Part II (Consumer Choices and Insurance Competition through Health Benefit Exchanges); see also *id.* § 1312(f) (codified at 42

government, or by multi-state compacts.⁹⁷ People whose income is 100% to 400% of the federal poverty level will be eligible to receive a federal tax credit to cover the premium for purchasing private health insurance.⁹⁸ Additionally, insurers that participate in Exchanges must meet a set of standards that render them “qualified” to offer plans through Exchanges; one of the more important requirements is coverage of “essential health benefits.”⁹⁹

The ACA defines “essential health benefits” to include at least the items and services that fall within ten specified categories of care: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services.¹⁰⁰ The essential health benefits may only be subject to limited cost sharing.¹⁰¹ Insurers may cover more than the essential health benefits but not less.¹⁰² Likewise, states that operate exchanges may require more essential health benefits to be covered than this list commands—it serves merely as a starting point.¹⁰³

The ACA contains many new federal rules for private health insurance, some of which apply to all private insurers, regardless of the market(s) in which they operate, and some of which apply only to those insurers that qualify to participate in exchanges. One

U.S.C. § 18032(f)) (explaining who is a “qualified individual” for purposes of purchasing insurance through Exchanges).

97. Pub. L. 111-148 §§ 1311, 1321 (codified at 42 U.S.C. §§ 18031, 18041).

98. While the ACA states that people from 100–400% of the federal poverty level are eligible for tax credits, *id.* § 1401 (codified at 42 U.S.C. § 36B(c)), people from 100% to 133% of the federal poverty level are eligible for Medicaid and will not be eligible to receive the tax credits so long as they are eligible for Medicaid. *See* 77 Fed. Reg. 30377 (2012). In response to comments, HHS described that people from 100–133% of the federal poverty level would typically be eligible for and enrolled in Medicaid thus not eligible for premium assistance through tax credits, but that some people will not be eligible for Medicaid and will therefore be able to receive premium assistance. *See id.* at 30378, 30387. Thus, the implementing regulations specify that someone eligible for “Minimum Essential Coverage” through Medicaid would not qualify for the premium assistance, but that someone ineligible for Medicaid (perhaps due to state failure to expand Medicaid) would be eligible for premium assistance. *See id.* at 30387.

99. 42 U.S.C. §§ 18021, 18022 (2012) (defining “qualified health plan” and “essential health benefits”).

100. *Id.* § 18022.

101. *Id.* § 18022(c).

102. *Id.* § 18022(b)(1).

103. *Id.* § 18031(d).

requirement that applies to group and individual insurance issuers, regardless of participation in exchanges, is coverage of “preventive health services” as defined by the Preventive Service Task Force.¹⁰⁴ This provision falls within the ACA’s Title I requirements that are designed to “improv[e] coverage” and describes that “[all] group health plan[s] and . . . health insurance insurer[s] offering group or individual health insurance coverage shall . . . provide coverage for and shall not impose any cost sharing requirements . . . with respect to women, such additional preventive care and screenings . . . provided for in comprehensive guidelines supported by the [HRSA].”¹⁰⁵ This rule fits with the prohibition against rating insurance higher for women (so-called “gender rating”) and with the requirement that maternity care be covered by plans in Exchanges. All of these new provisions will “improve coverage.”¹⁰⁶

The IOM has followed the ACA’s order to consider the health needs of women by instructing that certain elements of care for women should be covered without the copayment typically required by insurers.¹⁰⁷ That list includes prenatal care and testing, testing for sexually transmitted infections, all Food and Drug Administration approved forms of contraception and sterilization, domestic violence screening and treatment, and “at least one well-woman visit” per year.¹⁰⁸ The IOM recommendation, though otherwise comprehensive, does not and cannot include abortion.

The ACA also expands Medicaid, the program that has provided a public healthcare safety net for the poor since 1965, to everyone up to

104. *Id.* § 300gg-13.

105. *Id.* § 300gg-13(a)(4).

106. *See id.*

107. *See* INST. OF MED. OF THE NAT’L ACADS., CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 109–16 (2011), available at http://books.nap.edu/openbook.php?record_id=13181 (“[r]ecommending for consideration as a preventing service for women: the full range of Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity”); *Clinical Preventive Services for Women: Closing the Gaps*, INST. OF MED. 1 (July 2011), http://www.iom.edu/~media/Files/Report%20Files/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps/preventiveservicesforwomenreportbrief_updated2.pdf (describing the health benefits the ACA directs toward women, which include limiting co-payments).

108. *Clinical Preventive Services for Women*, INST. OF MED. 1 (July 2011), http://www.iom.edu/~media/Files/Report%20Files/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps/preventiveservicesforwomenreportbrief_updated2.pdf.

133% of the federal poverty level.¹⁰⁹ Medicaid is a federal-state partnership that contains mandatory elements by which states must abide if they want to receive federal funding.¹¹⁰ Medicaid has long mandated coverage of pregnant women, women with young children, and disabled women, but it has never required coverage of non-disabled, non-elderly childless adults.¹¹¹ The ACA eradicates longstanding limitations on Medicaid that extended the program to only the “deserving poor” because Medicaid will cover all adults under age sixty-five, regardless of reproductive or parental status, by January 1, 2014.¹¹²

B. Public Insurance

Medicaid covers approximately forty percent of all births in the United States.¹¹³ Historically, medical welfare programs, including programs that predated Medicaid, have covered pregnant women.¹¹⁴ This set of women has benefited from the access to healthcare that Medicaid facilitates, and, in fact, pregnant women in particular have benefited from more generous coverage than other women,¹¹⁵ but they also have suffered from the limitations that the Hyde Amendment imposes. Medicaid will now cover another group of women, childless women under the age of sixty-five, who will gain access to essential health benefits just like women in the private insurance exchanges.¹¹⁶ Like pregnant women and mothers, this new

109. 42 U.S.C. § 1396a.

110. *Id.*

111. *Id.* § 1396a(a)(10)(A); see also Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 439–46 (2011) (explaining the entrenched categories of eligibility in the Medicaid program and predecessor programs).

112. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

113. *Issue Brief: 2010 Maternal and Child Health Update: States Make Progress Towards Improving Systems of Care*, NGA CENTER FOR BEST PRACTICES 12 (Jan. 19, 2011), <http://www.nga.org/files/live/sites/NGA/files/pdf/MCHUPDATE2010.PDF>. The percentage of births covered by Medicaid in each state varies quite widely. See *id.* at 13.

114. Huberfeld, *supra* note 111, at 438–49 (explaining the historical roots of Medicaid’s selective coverage).

115. States have the option to expand Medicaid eligibility to pregnant women up to 185% of the federal poverty level, and many of them do so. See *Income Eligibility Limits for Pregnant Women as a Percent of Federal Poverty Level (FPL)*, January 2013, KAISER FAM. FOUND. (Jan. 1, 2013), <http://kff.org/medicaid/state-indicator/income-eligibility-fpl-pregnant-women/>. As this chart shows, the Children’s Health Insurance Program allows states to cover pregnant women above 185% of the federal poverty level. See *id.*

116. 42 U.S.C. § 1396(k).

group of women will be subject to the Hyde Amendment.¹¹⁷ The current prediction is that the Medicaid expansion will cover approximately 4.6 million new women of reproductive age, all of whom will be subject to this restriction.¹¹⁸

Uninsured women newly enrolled in Medicaid will experience a net gain in healthcare access, as the ACA creates a new Medicaid insurance coverage.¹¹⁹ Medicaid has required coverage of pregnant women, mothers, elderly women, and permanently disabled women, but not other adult women.¹²⁰ This limitation and others like it have facilitated a program that covers children but not their parents, as parents historically only have been eligible for Medicaid at very low levels of income.¹²¹ Thus, Medicaid has experienced coverage gaps that affect families, despite well-understood risks for disease spread among family members,¹²² and despite understanding that a woman's health long before pregnancy can impact the course of a pregnancy.¹²³ Women have been treated as deserving of Medicaid's assistance to ensure healthy pregnancies and to reduce infant mortality; the Medicaid expansion helps to eradicate this limited approach to women's health.

On the other hand, in spite of this net gain of access to care, these newly covered Medicaid enrollees nevertheless will not have access to one of the most common procedures for women in the United States. Restrictions on federal funding for abortion procedures are almost as

117. *Id.* § 18023(b)(1)(B)(i) (referring to the restriction on funding for the Department of Health and Human Services, which is the Hyde Amendment).

118. Genevieve M. Kenney et al., *Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?*, URB. INST. (Aug. 2012), <http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf>.

119. Erin Armstrong, *10 Reasons the Medicaid Expansion Is Good for Women*, NAT'L HEALTH L. PROGRAM (Aug. 13, 2012), http://www.healthlaw.org/images/stories/2012_08_13_Reasons_Medicaid_Good_Women.pdf.

120. 42 U.S.C. § 1396a(a)(10)(A). States have also had the option of covering women and men with breast cancer, women with cervical cancer, and uninsured women's family planning services. *Id.* § 1396a(a)(10)(A)(ii)(XVIII).

121. See *Quick Take: Who Benefits from the ACA Medicaid Expansion?*, KAISER FAM. FOUND. (June 14, 2012), http://www.kff.org/medicaid/quicktake_aca_medicaid.cfm.

122. See, e.g., Karla L. Hanson, *Is Insurance for Children Enough? The Link Between Parents' and Children's Use of Health Care Revisited*, 35 INQUIRY 294 (1998).

123. In the global health context, this is sometimes called the "life-course" perspective on women's health. See, e.g., Phyllis Moen et al., *Successful Aging: A Life-Course Perspective on Women's Multiple Roles and Health*, 97 AM. J. SOC. 1612 (1992).

old as *Roe v. Wade*.¹²⁴ As discussed *supra*, the Hyde Amendment has attached as an annual rider to HHS funding since 1977, and it limits Medicaid to paying for abortions when the life of the mother is in danger (and sometimes in instances of incest, rape, and jeopardized health, though the breadth of the restriction varies from year to year).¹²⁵

Thus, low-income women have had a three-front war in reproductive health: they have had less money to pay for contraceptives (despite federal funding for family planning through Medicaid and Title X) and therefore were more likely to have unintended pregnancies,¹²⁶ they are less likely to be able to obtain an abortion without significant sacrifice because Medicaid almost never pays for the procedure,¹²⁷ and few doctors participate in Medicaid, reducing poor women's ability to find physicians to provide their healthcare.¹²⁸ The ACA helps to address the first problem by requiring insurers to provide contraceptive coverage for all women. Arguably, poor women will now have better control over their reproductive lives, and even states with waivers seemingly will not be able to require copayments for prescription contraception, as essential health benefits apply to Medicaid's expansion population as well as private health plans in Exchanges.¹²⁹ The health benefits of contraception are incontrovertible, and they include not only prevention of unexpected pregnancy but also such benefits as pregnancy spacing and further "side" benefits of better economic status and better educational attainment that attend being able to control reproductive capacity.¹³⁰ The ACA helps to rectify the

124. 410 U.S. 113 (1973).

125. Pub. L. No. 94-439, § 209, 90 Stat. 1418, 1434 (1976).

126. *In Brief: Facts on Induced Abortion in the United States*, GUTTMACHER INST. (Aug. 2011), http://www.guttmacher.org/pubs/fb_induced_abortion.html; see also Kelli Stidham Hall et al., *Determinants of and Disparities in Reproductive Health Service Use Among Adolescent and Young Adult Women in the United States, 2002–2008*, 102 AM. J. PUB. HEALTH 2 (2012).

127. See Ikemoto, *supra* note 9, at 741–42 (describing how funding and other restrictions on abortion "impact low-income women the hardest").

128. See generally Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 AM. J. L. & MED. 191 (1995) (explaining how physician refusal to participate in Medicaid perpetuates a two-tier healthcare system for people with money and people without).

129. 42 U.S.C. § 1396u-7(b)(5) (2012).

130. Comm. on Healthcare for Underserved Women, *Benefits to Women of Medicaid Expansion Through the Affordable Care Act*, AM. C. OBSTETRICIANS & GYNECOLOGISTS (Jan. 2013), http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Benef

contraception inaccessibility problem as well as general medical access problems for poor women.¹³¹ The Medicaid expansion will enable poor women, regardless of their reproductive status, to access consistent healthcare.

The second front in poor women's reproductive health is greatly complicated by the ACA's amplifications of limitations on federal funding of abortions in most circumstances.¹³² More to the point in the context of public insurance, the ACA not only continues but also expands the strictures on Medicaid enrollees who need to access abortion by applying the Hyde Amendment to the expansion population.¹³³ These restrictions mean that any woman on Medicaid who needs an abortion will have to pay out of pocket. Women enrolled in Medicaid by definition are impoverished and cannot afford the expense without sacrificing other basic necessities, such as food, shelter, and clothing.¹³⁴ The Medicaid expansion exacerbates this aspect of women's reproductive health struggles.¹³⁵

its_to_Women_of_Medicaid_Expansion-Affordable_Care_Act; see also Comm. on Healthcare for Underserved Women, *The Uninsured*, AM. C. OBSTETRICIANS & GYNECOLOGISTS (Sept. 2008), http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/The_Uninsured.

131. See 42 U.S.C. § 1396a(a)(10)(A).

132. The federal government's position on funding abortion is somewhat mysterious given that a strong majority of the population believes that *Roe v. Wade* should not be overturned, as was evidenced by polls on the recent fortieth anniversary of the decision. See *Roe v. Wade at 40: Most Oppose Overturning Abortion Decision*, PEW RES. CENTER, <http://www.pewforum.org/Abortion/roe-v-wade-at-40.aspx> (last visited Apr. 24, 2013). The report summarizes:

As the 40th anniversary of the Supreme Court's *Roe v. Wade* decision approaches, the public remains opposed to completely overturning the historic ruling on abortion. More than six-in-ten (63%) say they would not like to see the court completely overturn the *Roe v. Wade* decision, which established a woman's constitutional right to abortion at least in the first three months of pregnancy. Only about three-in-ten (29%) would like to see the ruling overturned. These opinions are little changed from surveys conducted 10 and 20 years ago.

Id.

133. 42 U.S.C. § 18023(b)(1)(B)(i) (referring to the restriction on funding for the Department of Health and Human Services, which is the Hyde Amendment).

134. Heather Boonstra & Adam Sonfield, *Rights Without Access: Revisiting Public Funding of Abortion for Poor Women*, GUTTMACHER REP. ON PUB. POL'Y (Apr. 2000), <http://www.guttmacher.org/pubs/tgr/03/2/gr030208.pdf>.

135. See Janet Dolgin & Katherine R. Dieterich, *The "Other" Within: Health Care Reform, Class, and the Politics of Reproduction*, 35 SEATTLE U. L. REV. 377, 379–81(2012) (highlighting how limits on reproductive care disproportionately impact poor women).

The third front is only minimally helped by the ACA. Some commentators are concerned that the ACA does not do enough to facilitate entry of primary care physicians into the healthcare system in time to accommodate all of the new patients who will be covered by health insurance and seeking care.¹³⁶ More specifically in the Medicaid context, the ACA increased the rates of Medicaid providers to the same payment levels as Medicare primary care providers for the years 2013 and 2014.¹³⁷ The idea was to encourage more physicians to become Medicaid participating providers by the lure of the higher reimbursement so that they would be in the system and ready to accept the expansion population in 2014.¹³⁸ Unfortunately, the increase does not extend beyond 2014,¹³⁹ which makes it unlikely that the primary care physician shortage will be permanently solved, especially for Medicaid patients.

This three-front war on low-income women has been limited, for the most part, to Medicaid enrollees. But the ACA will introduce these access problems to limited-income women who rely on federal subsidies to obtain private health insurance. The next section describes how the ACA greatly increases the scale of limitations on access to abortion through private insurance.

C. Private Insurance

Before the ACA was enacted, state law restrictions on private insurance coverage of abortion were not common, and most people with employer-sponsored insurance had coverage for the procedure.¹⁴⁰ Nevertheless, a cluster of private insurance restrictions have existed at the state level. Most notably, a handful of states prevented private health insurers from providing abortion coverage through their general policies, meaning plan enrollees had to pay for

136. See Marshall B. Kapp, *Conscripted Physician Services and the Public's Health*, 39 J. L. MED. & ETHICS 414 (2012); Leighton Ku et al., *The States' Next Challenge—Securing Primary Care for Expanded Medicaid Populations*, 364 NEW ENG. J. MED. 364, 493–95 (2011).

137. Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, § 1202, 124 Stat. 1029 (codified at 42 U.S.C. § 1396a(a)(13)).

138. See Rene Bowser, *The Affordable Care Act and Beyond: Opportunities for Advancing Health Equity and Social Justice*, 10 HASTINGS RACE & POVERTY L. J. 69, 83–84 (2012).

139. Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, § 1202, 124 Stat. 1029 (codified at 42 U.S.C. § 1396a(a)(13)).

140. *Memo on Private Insurance Coverage of Abortion*, GUTTMACHER INST. (Jan. 19, 2011), <http://www.guttmacher.org/media/inthenews/2011/01/19/index.html>.

a separate abortion rider.¹⁴¹ In addition, some states have refused to allow abortion coverage for state employees.¹⁴² Federal law has also limited privately insured women's access to abortions through public insurance coverage restrictions and by allowing healthcare providers to opt out of performing abortion and sterilization procedures for reasons of conscience.¹⁴³

The ACA dramatically changes the visibility of the issue of private insurance for abortion coverage at both the federal and the state levels.¹⁴⁴ Even though the ACA requires all health insurers to cover preventive health care for women, and even though maternity care is specifically listed as an essential health benefit for insurers to cover in the Exchanges, the ACA directly and indirectly limits private insurance coverage for abortion. The law pushes private insurance restrictions much farther than they reached in most states before its passage by omitting abortion from the definition of essential health benefits¹⁴⁵ and by requiring riders on all of the policies obtained through the Exchanges regardless of whether they are established by the federal government or the states.¹⁴⁶ This will force insurers to limit their packages of covered benefits because insurers will not want to have separate plans for Exchange-based and non-Exchange-based clientele.¹⁴⁷

The ACA specifically excludes abortion from essential health benefits, both as such benefits are defined and as a gatekeeping requirement for Exchange participation.¹⁴⁸ The original exclusion was

141. See *infra* notes 155–65 and accompanying text.

142. *Restricting Insurance Coverage of Abortion*, GUTTMACHER INST., http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf (last updated July 1, 2013) (reporting that eighteen states prohibit insurance coverage of abortion for state employees and providing a chart of all fifty states' insurance policy limitations).

143. See, e.g., 42 U.S.C. § 300a-7 (the "Church amendment"); 42 U.S.C. § 238n (the "Danforth Amendment"); Consolidated Appropriations Act of 2008, Pub. L. No. 110-161, § 508(d)(1), 121 Stat. 1844, 2209 (2007) (the "Weldon Amendment").

144. See, e.g., Magda Schaler-Hayes et al., *Abortion Coverage and Health Reform: Restrictions and Options for Exchange-Based Insurance Markets*, 15 U. PA. J.L. & SOC. CHANGE 323 (2012).

145. 42 U.S.C. § 18021 (defining essential health benefits, which does not include abortion).

146. 42 U.S.C. § 18023 (special rules for abortion coverage in exchanges).

147. Thus far, only one state—Washington—is seriously debating requiring qualified health plans in Exchanges to cover abortion services. See Jonathan Kaminsky, *Washington State May Mandate Abortion Insurance*, BOS. GLOBE, Mar. 24, 2013, <http://www.bostonglobe.com/news/nation/2013/03/23/wash-state-weighs-first-abortion-insurance-mandate/7wfHQTMiYiJgWNY4nDZzBL/story.html>.

148. 42 U.S.C. § 18023.

written permissively, indicating that Title I of the ACA did not require qualified health plans to provide abortion coverage.¹⁴⁹ But the original language was replaced by Title X of the ACA, which amended the language of Title I significantly.¹⁵⁰ Title X provided in pertinent part, “A State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for such prohibition.”¹⁵¹ In other words, the ACA invited states to pass laws prohibiting coverage of abortions in Exchanges. The section also permits private insurers to choose whether to cover abortions while clarifying that essential health benefits do not include abortions (and therefore insurers need not cover abortion to participate in Exchanges).¹⁵² This section further restricts payment for abortions by forbidding use of federal tax credits in Exchanges to pay for abortions, except in circumstances permitted by the Hyde Amendment.¹⁵³ Otherwise, the qualifying health plans are responsible for segregating federal funds from personal funds, as only personal funds may be used for covering abortions (except in the instances of rape, incest, and life endangerment).¹⁵⁴

A number of states have forbidden qualifying insurers from covering abortion, whether or not the state has chosen to construct its own Exchange.¹⁵⁵ This trend reveals that the federal government has encouraged the states to become bolder in their restrictions on covering abortion through private insurance. Until 2010, only five states had enacted laws forbidding private insurers from covering abortion through general policy provisions: North Dakota,¹⁵⁶

149. *Id.*

150. Pub. L. No. 111-148, § 10104 (codified in scattered sections of 42 U.S.C.).

151. *See id.* The state may also repeal such a law.

152. 42 U.S.C. § 18021 (defining a qualified health plan for Exchange purposes).

153. 42 U.S.C. § 18023(b).

154. Exec. Order No. 13535, 75 Fed. Reg. 15599 (Mar. 24, 2010), *reprinted as amended in* 42 U.S.C. § 18023 app.

155. *State Policies in Brief: Restricting Insurance Coverage of Abortion*, GUTTMACHER, http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf (last updated July 1, 2013).

156. N.D. CENT. CODE § 14-02.3-03 (2011) (“No health insurance contracts, plans, or policies delivered or issued for delivery in this state may provide coverage for abortions, including the elimination of one or more unborn children in a multifetal pregnancy, except by an optional rider for which there must be paid an additional premium. Provided, however, that this section does not apply to the performance of an abortion necessary to prevent the death of the woman.”).

Missouri,¹⁵⁷ Idaho,¹⁵⁸ Kentucky,¹⁵⁹ and Oklahoma.¹⁶⁰ These laws prohibited private insurance companies from providing health insurance coverage for abortions unless the consumer purchased a separate rider for abortion coverage. These laws appear to have had

157. MO. REV. STAT. § 376.805 (2013). Missouri was the first of these five states to incorporate a ban against paying for abortions through Exchanges. Thus, the amended language of the law reads:

1. No health insurance contracts, plans, or policies delivered or issued for delivery in the state shall provide coverage for elective abortions except by an optional rider for which there must be paid an additional premium. For purposes of this section, an “elective abortion” means an abortion for any reason other than a spontaneous abortion or to prevent the death of the female upon whom the abortion is performed.

2. Subsection 1 of this section shall be applicable to all contracts, plans or policies of:

(1) All health insurers subject to this chapter; and

(2) All nonprofit hospital, medical, surgical, dental, and health service corporations . . . ; and

(3) All health maintenance organizations.

3. No health insurance exchange established within this state or any health insurance exchange administered by the federal government or its agencies within this state shall offer health insurance contracts, plans, or policies that provide coverage for elective abortions, nor shall any health insurance exchange operating within this state offer coverage for elective abortions through the purchase of an optional rider

Id. Notably, Missouri was not the first state to prohibit payment for abortions through Exchanges. *See, e.g.,* Julian Pecquet, *Missouri Fifth State to Opt Out of Abortion Coverage in State Insurance Exchange*, HILL HEALTHWATCH (July 14, 2010, 5:53 PM), <http://thehill.com/blogs/healthwatch/health-reform-implementation/108849-missouri-fifth-state-to-opt-out-of-abortion-coverage-in-state-insurance-exchange>.

158. IDAHO CODE ANN. § 41-2142 (2013) (“All policies, contracts, plans or certificates of disability insurance delivered, issued for delivery or renewed in this state after the effective date of this section shall exclude coverage for elective abortions. Such exclusion may be waived by endorsement and the payment of a premium therefor. Availability of such coverage shall be at the option of the insurance carrier.”). Idaho passed a new law prohibiting abortion coverage in exchanges on April 1, 2011. *See* IDAHO CODE ANN. §41-1848 (2013).

159. KY. REV. STAT. ANN. § 304.5-160 (West 2012) (“No health insurance contracts, plans or policies delivered or issued for delivery in the state shall provide coverage for elective abortions except by an optional rider for which there must be paid an additional premium. For purposes of this section, an ‘elective abortion’ means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.”).

160. OKLA. STAT. tit. 63, § 1-741.2 (2011) (“No health insurance contracts, plans, or policies delivered or issued for delivery in this state shall provide coverage for elective abortions except by an optional rider for which there shall be paid an additional premium.”), *repealed by* 2011 Okla. Sess. Laws 92.

a deterrent effect, at least to a degree.¹⁶¹ For example, the vice president of Anthem Blue Cross Blue Shield of North Dakota, which covers approximately eighty percent of North Dakotans, stated that no member has purchased the insurance rider.¹⁶² In Missouri and Kentucky, Anthem Blue Cross Blue Shield representatives claimed that very few citizens are aware of the option to purchase the rider.¹⁶³ In Idaho, Anthem does not advertise the abortion rider option, and patients must specifically request it.¹⁶⁴ The economics of paying for a rider are questionable; a woman and her family would be better off saving for the proverbial rainy day than paying for an actuarially unfavorable rider. But even if a woman wanted to carry an abortion-specific rider, it appears that private insurers do not offer them in any meaningful manner.¹⁶⁵

The ACA gave state legislation such as this the imprimatur of the federal government.¹⁶⁶ As a result, many more state legislatures have both proposed and passed separate insurance rider bills across the country. Prior to the enactment of the ACA in 2010, only the five states discussed above had passed laws that prohibited private insurance coverage for abortion.¹⁶⁷ But Congress ensured that states have the option to refuse to permit insurance coverage for abortions in the newly established Exchanges when it passed the amending, companion legislation to the ACA.¹⁶⁸ Consequently, some of the states that had abortion coverage limitations prior to the ACA have expanded the prohibition on insurance coverage to the Exchanges.¹⁶⁹

161. See Peter Slevin, *Insurers Report on Use of Abortion Riders*, WASH. POST, Mar. 14, 2010, http://www.washingtonpost.com/wp-dyn/content/article/2010/03/13/AR2010031302139_pf.html.

162. See *id.*

163. See *id.*

164. See *id.*

165. See Schaler-Hayes et al., *supra* note 144, at 362–63.

166. 42 U.S.C. § 18023(b)(1) (2012).

167. See *supra* notes 156–60 and accompanying text.

168. See Schaler-Haynes et al., *supra* note 144, at 339–44 (detailing the legislative history of the insurance coverage restrictions in the ACA); see also David Herszenhorn & Robert Pear, *Obama Rallies Democrats in Final Push for Health Bill*, N.Y. TIMES, Mar. 20, 2010, <http://www.nytimes.com/2010/03/21/health/policy/21health.html> (describing the prominent role of abortion coverage in the last push to pass the ACA).

169. Idaho, Missouri, North Dakota, and Oklahoma have introduced or passed legislation restricting coverage of abortion in state exchanges. See *Health Reform and Abortion Coverage in the Insurance Exchanges*, NAT'L CONF. ST. LEGISLATURES (Oct. 2012), <http://www.ncsl.org/issues-research/health/health-reform-and-abortion-coverage.aspx> (listing state laws that restrict insurance coverage of abortion in state exchanges).

More notably, other states that previously had no such regulations have proposed bills or enacted laws to that effect.¹⁷⁰ As of February 1, 2013, twenty states had enacted laws prohibiting qualified plans in Exchanges from covering abortion.¹⁷¹

The federal government has signaled that it does not take the privacy right that protects women's access to abortions seriously, and the states are following this example. The ACA has created a federal structure that allows state lawmakers who desired private insurance abortion coverage prohibitions to pursue this legislative option more aggressively. Unsurprisingly, states that are prohibiting abortion coverage in Exchanges are also prohibiting other kinds of abortion access. Congress has sent a message that it is not going to protect women within the reach of federal funding.

III. THE IMPACT OF *NFIB v. SEBELIUS*

On June 28, 2012, the Supreme Court decided *National Federation of Independent Business v. Sebelius* (*NFIB*), a high-profile and controversial decision that upheld the ACA's requirement for minimum insurance coverage (the "individual mandate") as a permissible exercise of Congress's power to tax while also holding that the expansion of Medicaid impermissibly coerced the states into accepting conditions on federal spending.¹⁷² This opinion held for the first time that Congress's spending power could be limited by judicial enforcement of the Tenth Amendment.¹⁷³ The opening statement of

170. See *id.* (listing Alabama, Arizona, Florida, Idaho, Indiana, Kansas, Louisiana, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Oklahoma, Tennessee, Utah, Virginia, and Wisconsin as the states that have enacted legislation preventing insurance coverage of abortion); see also *State Policies in Brief: Restricting Insurance Coverage of Abortion*, GUTTMACHER INST., http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf (last updated July 1, 2013).

171. *State Policies in Brief: Restricting Insurance Coverage of Abortion*, GUTTMACHER INST., http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf (last updated July 1, 2013).

172. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2608–09 (2012). In the context of the *NFIB* opinion, the Court appeared to be concerned with protecting an individual liberty that can only be described as a right not to purchase health insurance. Because the Court was concerned with this unrecognized, arguably non-cognizable liberty interest, Chief Justice Roberts and the Joint Dissent found that the commerce power does not sufficiently support the enactment of the individual mandate. *Id.* at 2590.

173. *Id.* at 2630 (Ginsburg, J., concurring in part and dissenting in part). For a thorough deconstruction of the Medicaid aspect of the decision, see generally Nicole Huberfeld et al., *Plunging into Endless Difficulties: Medicaid and Coercion in National Federation of Independent Business v. Sebelius*, 93 B.U. L. REV. 1 (2013).

Chief Justice Roberts's opinion makes it clear that Court-enforced federalism will be central to the decision, describing federalism as a doctrine that protects the states in the name of individual liberty.¹⁷⁴

In the context of the Medicaid expansion, the Court relied on a more straightforward concept of federalism to police the line between federal and state power. A plurality of the justices found the Medicaid expansion to be unconstitutionally coercive because states have no real choice but to participate in the proposed expansion.¹⁷⁵ The Court held the expansion coercive because the states could not have anticipated the expansion of Medicaid to all impoverished citizens when they joined the limited program in 1965; because the plurality viewed the expansion as a "shift in kind, not degree;" and because the states could lose all of their Medicaid funding if they failed to expand their programs to all adults under age sixty-five, resulting in a deficit too great for the states to make up on their own.¹⁷⁶ The remedy for the ACA's unconstitutional coercion was to sever the Secretary of HHS's authority to withhold all Medicaid funding from states that refuse to expand their Medicaid programs.¹⁷⁷ Thus, no part of the ACA or the Medicaid Act was struck down, but a mandatory element of the Medicaid program was rendered optional for the states.¹⁷⁸ In other words, states may opt out of the Medicaid expansion, and the only federal funding they jeopardize is the funding for the expansion population. They will be able to continue to participate in the Medicaid program without losing their existing funding. As I have written elsewhere, the Medicaid analysis suffers from a number of factual and jurisprudential faults.¹⁷⁹

174. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2578 (citing *New York v. United States*, 505 U.S. 144 (1992) ("[F]ederalism secures to citizens the liberties that derive from the diffusion of sovereign power.")). The opinion emphasizes that federalism protects individuals, much like Justice Kennedy's opinion in *Bond v. United States* and prior opinions that elevated federalism principles. *Bond v. United States*, 131 S. Ct. 2355 (2011) (holding that a criminal defendant may challenge the constitutionality of the federal statute under which she was convicted by raising Tenth Amendment concerns with the law).

175. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2603, 2608.

176. *Id.* at 2601–07.

177. *Id.* at 2607 (ruling that only expansion funding can be withheld if a state opts out of the Medicaid expansion).

178. *Id.* at 2642 (Ginsburg, J., concurring) (noting that the Court did not rule any provision of the ACA unconstitutional).

179. See Huberfeld et al., *supra* note 173, at 46–76; see also Nicole Huberfeld, *Heed Not the Umpire (Justice Ginsburg Called NFIB)*, 15 U. PA. J. CONST. L. HEIGHTENED SCRUTINY 43 (2013), available at <https://www.law.upenn.edu/live/files/1657->

NFIB produced at least three ramifications for women's healthcare access. First, *NFIB* jeopardizes the access to care that our poorest citizens would receive if states exercise the option to decline the Medicaid expansion. The Roberts plurality allowed states to opt out of the Medicaid expansion, which will directly impact women who would have enrolled in Medicaid in those states.¹⁸⁰ A number of states appear poised to reject the Medicaid expansion and the money it promises, even though studies consistently indicate that this appears to be against their economic self-interest. Thus, some women residing in states that exercise the "Red State Option"¹⁸¹ will have no insurance access either through Medicaid or the exchanges, because the ACA only provides federal subsidies to people from 100% to 400% of the federal poverty level. One recent study estimated that as many as four million women may be excluded from health insurance coverage due to states opting out of the Medicaid expansion.¹⁸² Many of the women who should be covered by the Medicaid expansion would be too poor to access private insurance through Exchanges, so even though they would not be subject to the tax penalty for failure to be covered by health insurance, they would not gain access to health insurance, either.

Though on the surface these women appear to face stagnation, data indicates that they are more likely to experience unintended pregnancies and more likely to seek abortion to end the pregnancies.¹⁸³ Thus, states that opt out of Medicaid expansion may see more poor women who cannot afford consistent contraception

huberfeld15upajconstlheightscrutiny432013pdf (highlighting the factual faults of the Roberts opinion).

180. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2607 (restricting the Secretary of the Department of Health and Human Services to withholding funding for the Medicaid expansion if states choose not to participate in the expansion); see also Huberfeld et al., *supra* note 173, at 6 (calling the Court's remedy to allow states to reject the Medicaid expansion while keeping their existing Medicaid programs and funding the "Red State Option").

181. Huberfeld et al., *supra* note 173, at 6.

182. Lindsay Rosenthal, *Interactive Map: Rejecting Medicaid Expansion Could Leave 4 Million Women Without Coverage*, CENTER FOR AM. PROGRESS (Feb. 27, 2013),

<http://www.americanprogress.org/issues/women/news/2013/02/27/54864/interactive-map-rejecting-medicaid-expansion-could-leave-4-million-women-without-coverage/>.

183. See Rachel K. Jones & Megan L. Kavanaugh, *Changes in Abortion Rates Between 2000 and 2008 and Lifetime Incidence of Abortion*, 117 *OBSTETRICS & GYNECOLOGY* 1358 (2011) (describing that abortion rates have dropped overall but have increased among poor women and women of color); see also Ikemoto, *supra* note 9, at 749–52.

seeking abortions and sacrificing life needs to obtain them. Notably, the states poised to opt out of the Medicaid expansion are also states that attempt to limit abortion access the most and that tend to have the most uninsured women and the highest federal Medicaid match.¹⁸⁴ They also tend to have the fewest female legislators.¹⁸⁵

Thus, adults who were not covered by their states' Medicaid programs prior to the ACA's enactment will not be saved by the private insurance subsidies offered to the remaining population, because some of them will be too poor to qualify for the tax subsidies that make private insurance affordable in the Exchanges. Although such women will also be too poor to be penalized for failing to carry health insurance, the greater problem is that they will have no health insurance coverage. These poor women will not gain any of the access to care facilitated by the ACA, and they may become more likely to seek abortions as a result.

Second, *NFIB* protects states that reject coverage of abortion in private insurance, but it also protects states that facilitate insurance coverage of abortion. The Roberts opinion carefully stated that its holding regarding the Medicaid expansion was limited to the expansion and did not implicate other aspects of the ACA.¹⁸⁶ Nevertheless, the Court indicated that state sovereignty will be protected from federal encroachments by exercises of conditional spending power.¹⁸⁷ In the context of abortion under the ACA, this seems to indicate that states may choose to either limit access to abortion or facilitate it, and movement in either direction likely would be protected state exercises of sovereignty pursuant to *NFIB*.

184. The most obvious example of this phenomenon is Texas, which has the highest number of uninsured individuals of any state, refuses to create an Exchange, is loudly protesting the Medicaid expansion, but which also has a very high federal match for its Medicaid program. See Melissa del Bosque, *Rick Perry's Refusal to Expand Texas' Medicaid Program Could Result in Thousands of Deaths*, TEX. OBSERVER (Jan. 2, 2013), <http://www.texasobserver.org/rick-perrys-refusal-to-expand-texas-medicaid-program-could-result-in-thousands-of-deaths>; Shan Li, *Protesters March to Urge Texas Gov. Rick Perry to Expand Medicaid*, L.A. TIMES, Mar. 6, 2013, <http://www.latimes.com/business/money/la-fi-mo-medicaid-texas-perry-20130306,0,368024.story>.

185. Ctr. for Am. Women & Politics, Eagleton Inst. of Politics, *Fact Sheet: Women in State Legislatures 2013*, RUTGERS U. (Apr. 2013), http://www.cawp.rutgers.edu/fast_facts/levels_of_office/documents/stleg.pdf. The states with the fewest female legislators, according to this study, are Louisiana, South Carolina, Oklahoma, Alabama, Utah, West Virginia, Mississippi, Wyoming, Arkansas, and North Dakota.

186. Nat'l Fed'n of Ind. Bus. v. Sebelius, 132 S. Ct. 2566, 2608–09 (2012).

187. *Id.* at 2601–08.

The ACA allows states to exclude abortion coverage from private insurance in exchanges.¹⁸⁸ But, it also allows states to continue covering abortion services if they so choose. Though the ACA acts as a beacon to state legislatures desiring limits on abortion, it also leaves the states that have covered abortion in Medicaid, or that otherwise would allow abortion coverage in Exchanges, to proceed in that manner as well. Though the number of states that have added private insurance restrictions on abortion coverage is startling, it is important to remember that three-fifths of states have not passed such legislation, and *NFIB* protects their decision equally.

Third, *NFIB* opens the door to further litigation regarding the rights of both states and individuals in the Medicaid program, because the coercion doctrine is up for grabs.¹⁸⁹ One recent example of a state getting creative with *NFIB*'s coercion holding can be found in a Seventh Circuit decision regarding Indiana's funding of Planned Parenthood.¹⁹⁰ Indiana passed a law that prevented all government funding, federal or state, from flowing to entities that provided any abortion services.¹⁹¹ Planned Parenthood and other plaintiffs, supported by the United States, challenged the law as violating Medicaid's "free choice of provider" requirement, which makes it so that Medicaid enrollees can receive services from any provider willing to accept Medicaid as reimbursement for services.¹⁹² Citing *NFIB*, Indiana attempted to assert that it was at risk of losing all of its Medicaid funding for noncompliance with a term of the Medicaid Act, but that the provisions of the Act were not federal law with which the state needed to comply because compliance was voluntary on the state's part.¹⁹³ The Seventh Circuit rejected this coercion argument, finding that it would be absurd to require the federal government to comply with the terms of the Medicaid Act but not the state that voluntarily participates in the Medicaid program.¹⁹⁴

188. See *supra* notes 140–65 and accompanying text.

189. Both Chief Justice Roberts and the Joint Dissent refused to articulate a rule for coercion, leaving its contours to lower court exploration. *Nat'l Fed'n of Ind. Bus.*, 132 S. Ct. at 2662 (Scalia, Kennedy, Thomas, Alito, JJ., dissenting).

190. See *Planned Parenthood of Ind., Inc. v. Comm'r of the Ind. State Dep't of Health*, 699 F.3d 962, 967 (7th Cir. 2012); *cert. denied*, 81 U.S.L.W. 3557 (May 28, 2013) (No. 12-1159).

191. *Id.* at 968.

192. *Id.* (citing 42 U.S.C. § 1396a(a)(23)).

193. *Id.* at 976–77.

194. *Id.* The state's coercion argument was tied to its assertion that the free choice of provider provision does not give rise to private rights of action under §1983. *Id.* The Seventh Circuit rejected that argument as well. *Id.*

Indiana's loss on the coercion theory does not mean more states will not try similar tactics. Maine has attempted a coercion argument with regard to the ACA's maintenance of effort provision,¹⁹⁵ and Massachusetts claimed that the Defense of Marriage Act coerced the state into accepting a more limited version of marriage than its citizens desired.¹⁹⁶ Other states are sure to follow suit, in the context of the Medicaid expansion or even the Exchanges, and the exploration of coercion may lead to a further narrowing of access to women's medical care.

CONCLUSION

The ACA reflects a long-standing disconnect in the law by denying to women the "basic security" of providing insurance for a procedure that one in three women will need during their reproductive lifetime. On one hand, the access-enhancing elements of the ACA are likely to help women, who statistically earn lower wages, need more medical care, and live longer than men, to gain access to preventive and regular healthcare and to keep the insurance that they have. On the other hand, poor women and women of color will lose ground in access to abortion, because the ACA prevents insurance payment for abortions through both public and private insurance.¹⁹⁷ This new set of federal funding limits contradicts and undercuts the access-enhancing goals of the ACA. Further, by inviting state lawmakers to limit insurance coverage of abortion, the ACA amplifies existing barriers to women's reproductive care and further detaches abortion from holistic treatment of women's medical needs.

The ACA is likely to exacerbate the class divide in abortion services. Women with private health insurance who historically have had health plans that cover abortion will likely continue with this coverage. But the millions of women who will rely on Medicaid and tax subsidies to pay for private insurance in the Exchanges will be subjected to the Hyde Amendment with no alternative but to sacrifice life necessities to access a legal, non-experimental medical procedure.

195. *Mayhew v. Sebelius*, No. 12-2059, 2012 WL 4762101 (1st Cir. 2012).

196. *Massachusetts v. U.S. Dep't of Health & Human Servs.*, 682 F.3d 1, 5 (1st Cir. 2012).

197. See Emily Spitzer, *Fulfilling the Promise of Roe v. Wade: Let's Start with the President's Budget*, HUFFINGTON POST (Jan. 22, 2013, 1:33 PM) http://www.huffingtonpost.com/emily-spitzer/hyde-amendment-budget_b_2506668.html (Director of the National Health Law Program describing the disparate impact of federal spending decisions on poor women and women of color).

The *NFIB* federalism language provides protection to states that buck the anti-abortion tenor of the ACA, but it may also protect those states that have increased their abortion restrictions by preventing private insurance coverage of abortion. Whether such state limitations will give rise to additional access problems remains to be seen. In the meantime, women's sexual health remains a political football.