

# The “Other” Within: Health Care Reform, Class, and the Politics of Reproduction

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## I. INTRODUCTION

Americans have long been reluctant to develop a system of universal health care,<sup>1</sup> and they remain reluctant about implementing the Affordable Care Act, promulgated in 2010.<sup>2</sup> The United States spends more on health care per capita than any other nation,<sup>3</sup> yet the results of that expenditure are wanting.<sup>4</sup> Various explanations for the gap between spending and results refer to economic factors,<sup>5</sup> special interests,<sup>6</sup> political commitments,<sup>7</sup> and dedication to finding private solutions for public

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1. *Why Not the Best? Results From a National Scorecard on U.S. Health System Performance*, COMMONWEALTH FUND (Sept. 20, 2006), <http://www.commonwealthfund.org/Publications/Fund-Reports/2006/Sep/Why-Not-the-Best--Results-from-a-National-Scorecard-on-U-S--Health-System-Performance.aspx>.

2. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

3. Noam M. Levey, *U.S. Health care Spending Far Outpaces Other Countries*, L.A. TIMES, June 30, 2011, <http://articles.latimes.com/2011/jun/30/news/la-heb-health-spending-20110630>.

4. UNITED HEALTH FOUNDATION, AMERICA'S HEALTH RANKINGS: A CALL TO ACTION FOR PEOPLE & THEIR COMMUNITIES 9 (2007), *available at* [http://www.borderhealth.org/files/res\\_1246.pdf](http://www.borderhealth.org/files/res_1246.pdf) (noting the low rank of the United States compared to other nations with regard to life expectancies and infant mortality rates).

5. *See generally* LINDA GORDON, THE MORAL PROPERTY OF WOMEN: A HISTORY OF BIRTH CONTROL POLITICS IN AMERICA (2002) (examining economic and political dimensions of the nation's refusal to develop a universal health care system).

6. *Id.* at 284.

7. *See generally* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1984) (documenting the history of opposition to health care reform in the U.S.).

conundrums.<sup>8</sup> None of these explanations is wrong. None, however, tells the full story.

This Article offers a different explanation and focuses on the nation's opaque class system. It suggests that dedication to assumptions about class is an essential component of the nation's longstanding resistance to constructing a more equitable system of health care coverage.<sup>9</sup> This Article describes the nation's class ideology and how that ideology is reflected in national discourse about health care reform. Specifically, it illustrates these matters through the lens of American society's reactions to poor women in need of reproductive care.

The process leading to the Affordable Care Act's passage, as well as state and federal legislative responses in the year following the Act's passage, do not bode well for these women and their essential health needs. The political process of health care reform seemed to displace concern about the matter actually at issue—health care coverage—with concern about abortion and family-planning services for poor women.<sup>10</sup> Cliff-hanging negotiations about abortion coverage shaped the final congressional vote on the Act, and the law's passage depended on President Obama's executive order, which restricted the use of funds made available pursuant to the law for abortion coverage.<sup>11</sup>

Ten months later, the 112th Congress initiated its session in the House with the introduction of a bill to repeal the health care reform law completely,<sup>12</sup> and soon after, the House considered another bill aimed at cementing the ban on abortion funding through the health care reform law.<sup>13</sup> At the same time, many states passed or at least considered bills that limited funding for abortion and general reproductive care.<sup>14</sup> These laws disproportionately affect poor women.<sup>15</sup>

Thus, passage of a health care reform law reshaped and reinforced a narrative about poor women and their reproductive lives—a narrative that instantiates the nation's ideology of class. It is a narrative grounded on Americans' commitment to a highly competitive class system, the shape and boundaries of which remain obscure. It reflects the nation's

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8. GORDON, *supra* note 5, at 3.

9. In this Article, the term "ideology" does not refer to a system of false beliefs. Rather, it refers to the essential, often unstated, assumptions in terms of which people understand and act in the world. This use of the term follows that of the French anthropologist Louis Dumont. *See, e.g.*, LOUIS DUMONT, FROM MANDEVILLE TO MARX 22 (1977).

10. *See infra* Part IV.A & B.

11. *See infra* notes 193–203 and accompanying text.

12. H.R. 2, 112th Cong. (2011).

13. *See infra* notes 206–10 and accompanying text.

14. *See infra* Part IV.D.

15. *See infra* notes 258–62 and accompanying text.

intense anxiety about socioeconomic status in a universe where signs of status shift rapidly and are often murky.

Part II of this Article discusses the vulnerability of poor women who lack full coverage for reproductive health care. These women are likely to receive inadequate or even harmful care. Additionally, poor women are likely to receive that care later than women with adequate health care coverage or with other economic resources. Section A recites the disturbing tale of an abortion clinic in Philadelphia that served mostly poor, minority women. The story involves reproductive care at its very worst. Section B considers, more generally, how the nation has wrested reproductive control from poor women in the United States. It then examines the complicated ideological strands that lie beneath reproductive health care available to poor women.

Part III reviews responses to reproductive care for low-income women during the last decades of the twentieth century and provides the historical background needed for contextualizing the discussion in Part IV. Part IV reviews the role that abortion politics, and reproductive politics more generally, has played in the passage of, and in post-passage responses to, the health care reform law—the Patient Protection and Affordable Care Act.<sup>16</sup> This role has included federal and state challenges to public funding for family-planning services for poor women.<sup>17</sup>

Finally, Part V elaborates on material introduced in Part II. It considers assumptions about class that undergird opposition to health care reform. This Part argues that many assumptions that underlie opposition to health care reform also underlie opposition to public funding for abortion and family-planning services. In short, the abortion politics that marked the last weeks of congressional debate prior to passage of the Affordable Care Act provided a platform upon which the nation could contemplate the benefits and detriments of more universal health care coverage.

## II. POVERTY AND REPRODUCTIVE CHOICE

The politics of reproduction includes the social and jurisprudential debate about contraception, sterilization, and infertility, as well as the debate surrounding abortion and family-planning laws. Reproductive politics directly affects family life, relationships between men and women, and the self-identity of women. It also directly affects the health of women and children, and, more specifically, may affect the timing of

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16. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

17. See *infra* Part IV.C & D.

childbearing as well as the number of children that a woman will bear. And reproductive politics also encompasses a host of other significant issues. During the last half century, the politics of reproduction has served the interests of those concerned with broadening (or limiting) welfare, challenging (or cementing) traditional understandings of gender and family, glorifying (or deflating) medicine as a profession, determining childbearing patterns, and cementing (or exposing) class and racial discrimination.<sup>18</sup>

Although reproductive politics affects virtually all women and most men, its consequences have been particularly harsh for poor women.<sup>19</sup> The politics of abortion provides a poignant example of how disparities in the national health care system are created on the basis of economic status, albeit in another name. On its face, discourse about abortion in the United States has concentrated primarily on the ontological status of the embryo and the fetus, as well as on the value and social implications of safeguarding a “traditional” vision of family.<sup>20</sup> These issues would seem to render discourse about abortion similarly consequential for all socioeconomic groups. But the politics of abortion and reproduction reflect a set of assumptions about class deeply ingrained in the discourse. The result has not served poor people well.

It is unsurprising that poor women are the primary victims of reproductive politics. They are stigmatized not only because they are poor but also because they are poor *women*.<sup>21</sup> Assumptions about poverty and the reproductive lives of poor women merge; each set of assumptions intensifies the other. American society has long envisioned that a woman’s personal reproductive history is an essential parameter of her personhood. That notion has particular implications for poor women. Society attributes poverty to women’s reproductive irresponsibility far more than men’s. Moreover, American society has viewed nontraditional family choices among low-income people as evidence of “lower-class” irresponsibility.<sup>22</sup> In that context, society views poor women as “bad” moth-

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18. See generally Christine Dehlendorf & Tracy Weitz, *Access to Abortion Services: A Neglected Health Disparity*, 22 J. HEALTH CARE FOR POOR & UNDERSERVED 415 (2011).

19. See, e.g., *infra* notes 258–61.

20. Janet L. Dolgin, *Embryonic Discourse: Abortion, Stem Cells, and Cloning*, 31 FLA. ST. U. L. REV. 101, 104 (2003).

21. In addition, many of the women harmed by reproductive politics belong to minority groups. Maura Kelly, *Regulating the Reproduction and Mothering of Poor Women: The Controlling Image of the Welfare Mother in Television News Coverage of Welfare Reform*, 14 J. POVERTY 76, 77–79 (2010).

22. Bernard Weiner, Danny Osborne & Udo Rudolph, *An Attributional Analysis of Reactions to Poverty: The Political Ideology of the Giver and the Perceived Morality of the Receiver*, 15 PERSONALITY & SOC. PSYCHOL. REV. 199, 200 (2011). The authors reported: “[A]lthough low motivation and poor money management skills are perceived to be the dominant causes of poverty for

ers.<sup>23</sup> These assumptions reflect a wider tendency in American society to attribute poverty to irresponsibility in general and to laziness in particular.<sup>24</sup>

Section A of this Part argues that poor women who are anxious to abort a pregnancy but who are without coverage for the procedure are profoundly vulnerable.<sup>25</sup> The implications of the painful story described in section A are far-reaching insofar as the social and legal responses to abortion identified in that section are reflective of responses to reproductive care for poor women more generally.<sup>26</sup> Section B of this Part considers the wider context within which law and society in the United States deprive poor women of control over their reproductive choices.

#### A. The Worst of Care

In early 2011, a Philadelphia judge accepted a grand jury report that recommended that the city’s district attorney prosecute Dr. Kermit Gosnell, his wife, and members of his staff for crimes allegedly committed at Gosnell’s abortion clinic, the Women’s Medical Society.<sup>27</sup> The grand

men, poverty among women is more often attributed to irresponsible reproductive patterns and failure to establish a traditional nuclear family.” *Id.* (citations omitted).

23. See, e.g., Katha Pollitt, “Fetal Rights”: A New Assault on Feminism, in “BAD” MOTHERS: THE POLITICS OF BLAME IN TWENTIETH-CENTURY AMERICA 285, 288 (Molly Ladd-Taylor & Lauri Umansky eds., 1998).

24. In the late 1700s, Benjamin Franklin explained that poverty is a consequence of irresponsibility. SIMON P. NEWMAN, EMBODIED HISTORY: THE LIVES OF THE POOR IN EARLY PHILADELPHIA 143 (2003). Franklin further explained that laziness also produces poverty. *Id.*; see also *infra* notes 52–55.

25. See *infra* Part III.B (considering the Hyde Amendment and its consequences for poor women).

26. RAND CORP., DO PUBLIC ATTITUDES TOWARD ABORTION INFLUENCE ATTITUDES TOWARD FAMILY PLANNING? (2000), [http://www.rand.org/pubs/research\\_briefs/RB5042/index1.html](http://www.rand.org/pubs/research_briefs/RB5042/index1.html). The RAND analysis reported that by the end of the twentieth century, political responses to family-planning programs (including those offered pursuant to Title X of the Public Health Services Act) were “linked,” but only minimally, to the debate about abortion. *Id.* Yet, within a decade, the links between the debates about abortion and family planning became more charged. See, e.g., Christine Delargy, *Rick Santorum to Mitch Daniels: Defund Planned Parenthood in Indiana*, CBS NEWS (Apr. 28, 2011), [http://www.cbsnews.com/8301-503544\\_162-20058486-503544.html?tag=mncol;lst;2](http://www.cbsnews.com/8301-503544_162-20058486-503544.html?tag=mncol;lst;2) (reporting that former Indiana Senator Rick Santorum sought cuts in funding for Planned Parenthood and described Planned Parenthood as having “a very sordid history”); Amanda Marcotte, *The War on Contraception*, SLATE (Feb. 18, 2011), [http://www.slate.com/blogs/xx\\_factor/2011/02/18/tittle\\_x\\_planned\\_parenthood\\_and\\_the\\_republican\\_war\\_on\\_contraception.html](http://www.slate.com/blogs/xx_factor/2011/02/18/tittle_x_planned_parenthood_and_the_republican_war_on_contraception.html) (noting that Indiana Republican Representative Mike Pence introduced a bill aimed at prohibiting federal funding for clinics that provided family planning services—the “Title X Abortion Provider Prohibition Act”).

27. Presentment, *In re County Investigating Grand Jury XXIII*, Misc. No. 0009901-2008, C-17 (2008), available at <http://www.phila.gov/districtattorney/PDFs/PresentationFinalWomensMedical.pdf>; see also Report of the Grand Jury, *In re County Investigating Grand Jury XXIII*, Misc. No. 0009901-2008, C-17 (2008) [hereinafter Grand Jury XXIII Report], available at <http://www.phila.gov/districtattorney/PDFs/GrandJuryWomensMedical.pdf>. In January 2011, Judge Renee Cardwell Hughes accepted the grand jury report and “refer[red] it to the Clerk of Court for filing as a public

jury called Gosnell's clinic a "filthy fraud"<sup>28</sup> and recommended that he be tried for several counts of murder and infanticide.<sup>29</sup>

Gosnell ran the clinic for decades, but the state investigated the clinic's abortion business—and its often disastrous consequences for poor women—only by accident, as part of a drug-trafficking investigation involving prescription medications.<sup>30</sup> According to reports, patients at Gosnell's clinic were overdosed with dangerous drugs.<sup>31</sup> The grand jury described that Gosnell "spread venereal disease among [the patients] with infected instruments, perforated their wombs and bowels," and caused at least two deaths.<sup>32</sup> The grand jury also concluded that unlicensed clinic employees routinely provided care to Gosnell's patients.<sup>33</sup>

Further, the grand jury reported "official neglect" by the state's oversight agencies<sup>34</sup> and asserted that "[e]ven nail salons in Pennsylvania are monitored more closely for patient safety."<sup>35</sup> Gosnell's clinic seemed to specialize in late-term abortions. Many involved live births. If born alive, clinic employees allegedly killed the infants after birth, often by cutting the newborn's spinal cord.<sup>36</sup> Gosnell made a great deal of money from abortions performed on the women who came to his clinic:

We estimate that Gosnell took in as much as \$10,000 to \$15,000 a night, mostly in cash, for a few hours of work performing abortions. And this amount does not include the money he made as one of the top Oxycontin prescribers in the state. The Women's Medical So-

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record." *Id.*; see also, Larry Miller, *Poor, Minorities Abortion Victims*, NAT'L NEWSPAPER PUBLISHERS ASS'N (Jan. 21, 2011), [http://www.nnpa.org/index.php?option=com\\_content&task=view&id=4883&Itemid=63](http://www.nnpa.org/index.php?option=com_content&task=view&id=4883&Itemid=63)www.phillytrib.com.

Discussion of the Women's Medical Society in this Article reflects newspaper reports as well as the report of the grand jury. In January 2011, Gosnell was charged with eight counts of murder. Charges were also filed against nine of his employees. Sabrina Tavernise, *Doctor Is Charged in Killing of Newborns*, N.Y. TIMES, Jan. 19, 2011, at A15. At the time of publication, however, neither Gosnell nor the other potential defendants have been tried. Thus, this discussion does not, because it cannot, presume those defendants' legal guilt. In October 2011, two Gosnell employees pled guilty to third-degree murder. One pled guilty in connection with the death of a baby; the other pled guilty in connection with the death of a clinic patient. Associated Press, *Pennsylvania: Clinic Workers Plead Guilty to Murder*, N.Y. TIMES, Oct. 27, 2011, available at [http://www.nytimes.com/2011/10/28/us/abortion-clinic-workers-plead-guilty-to-murder.html?\\_r=2&emc=tnt&tntemail=y](http://www.nytimes.com/2011/10/28/us/abortion-clinic-workers-plead-guilty-to-murder.html?_r=2&emc=tnt&tntemail=y).

28. Grand Jury XXIII Report, *supra* note 27, at 1.

29. *Id.* at 219.

30. *Id.* at 19; Joseph Bottum, *To Live and Die in Philadelphia: The Abortionist's House of Horrors*, WKLY. STANDARD (Feb. 7, 2011), [http://www.weeklystandard.com/articles/live-and-die-philadelphia\\_537628.html](http://www.weeklystandard.com/articles/live-and-die-philadelphia_537628.html); Miller, *supra* note 27.

31. Grand Jury XXIII Report, *supra* note 27, at 1, 23.

32. *Id.* at 1.

33. *Id.* at 27–30.

34. *Id.* at 137.

35. *Id.*

36. Bottum, *supra* note 30.

ciety stands as a monument to an absolute disdain for the health and safety of women, and in many cases of babies who were born alive in this filthy clinic.<sup>37</sup>

Most of the clinic's patients were poor women of color.<sup>38</sup> According to a spokesperson for Philadelphia's Black Women's Health Project, the majority of women in Philadelphia who seek abortions are young, single, black, and very poor.<sup>39</sup> Despite the fact that abortions are generally legal,<sup>40</sup> and that the procedure is usually routine,<sup>41</sup> Medicaid offers almost no coverage for abortion in Pennsylvania.<sup>42</sup> The severe limitation on the availability of Medicaid funds for abortions has furthered the demedicalization of the procedure, especially for poor women.<sup>43</sup> As a consequence, poor women seeking abortions must often delay having them.<sup>44</sup> And when they do, they are "vulnerable to sub-standard providers" such as Gosnell and the other unlicensed workers employed at his clinic.<sup>45</sup>

Gosnell was apparently conscious of his patients' class status. Middle-class women who sought abortions at the Women's Medical Society seemed to have received superior services. The grand jury reported that when "a white girl from the suburbs" came to the clinic, she received better and far more respectful treatment than that provided to the majority of patients.<sup>46</sup> The grand jury report elaborated:

Only in one class of cases did Gosnell exercise any real care with these dangerous sedatives. On those rare occasions when the patient was a white woman from the suburbs, Gosnell insisted that he be

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37. Grand Jury XXIII Report, *supra* note 27, at 23.

38. Miller, *supra* note 27. Gosnell is himself African-American. *Id.*

39. *Id.* The Black Women's Health Project spokesperson reported that most of those seeking abortions in the city have incomes of less than \$15,000 a year. *Id.*

40. See *infra* notes 88–96 and accompanying text.

41. Miller, *supra* note 27.

42. Pursuant to the Hyde Amendment, federal Medicaid funds are not generally available to cover abortion. See *infra* note 103 and accompanying text (describing the Hyde Amendment's restrictions on the use of federal funds for abortions and its exceptions in cases of threat to the pregnant woman's life and, in certain years, also in cases of rape and incest). Pennsylvania is among the majority of states in which state funds cover very few abortions through Medicaid. Miller, *supra* note 27. Thirty-two states provide funds for Medicaid abortions only in cases of rape, incest, or endangerment of the life of the pregnant woman; two of these thirty-two states also provide funds in cases of fetal abnormality; and three offer funds in cases that threaten the pregnant woman with serious ill-health. GUTTMACHER INST., STATE POLICIES IN BRIEF, STATE FUNDING FOR ABORTION UNDER MEDICAID 1 (2011), [http://www.guttmacher.org/statecenter/spibs/spib\\_SFAM.pdf](http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf).

43. See *infra* note 125 and accompanying text.

44. See Dehlendorf & Weitz, *supra* note 18, at 417.

45. Miller, *supra* note 27 (quoting Susan Schewel, Executive Director of the Women's Medical Fund).

46. Grand Jury XXIII Report, *supra* note 27, at 61–62 (quoting testimony of Tina Baldwin); see also Miller, *supra* note 27.

consulted at every step. When an employee asked him why, he said it was “the way of the world.”<sup>47</sup>

The sad tale of Gosnell’s clinic echoes other related stories. Some are about abortion. Others are about limited access to medical care or about the state’s failure to take an interest in preventing stories such as that of the Women’s Medical Society. Others still are about color, class, and how health care is different for those with adequate resources and those with fewer resources. Certainly, the horrendous tale of Gosnell’s clinic illustrates the dismal reality for poor people, and poor women in particular, in a health care system rife with wide class disparities in access to care.<sup>48</sup>

### *B. Poverty, Responsibility, and Control*

The story of Gosnell’s clinic, when viewed within the context of the politics of abortion, can be used by both pro-life and pro-choice adherents to support their respective positions. Indeed, at the start of its lengthy report, the Philadelphia grand jury that investigated Gosnell’s clinic acknowledged that the case would likely “be used by those on both sides of the abortion debate” to further their particular ideological ends.<sup>49</sup> The report continued:

We ourselves cover a spectrum of personal beliefs about the morality of abortion. For us as a criminal grand jury, however, the case is not about that controversy; it is about disregard of the law and disdain for the lives and health of mothers and infants. We find common ground in exposing what happened here, and in recommending measures to prevent anything like this from ever happening again.<sup>50</sup>

Thus, the grand jury recognized that the ramifications of the story extend *beyond* the politics of abortion. Fundamentally, it is a story of unequal access to health care and about the devastating consequences of that inequality for poor women. As described in the grand jury report, the case involved a clinic taking advantage of the vulnerable population of poor women for pecuniary motives.<sup>51</sup> This conduct was made possible by a national health care system in which the needs of poor women are too often unmet.

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47. Grand Jury XXIII Report, *supra* note 27, at 7.

48. *See generally* UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (Brian D. Smedley et al. eds., 2003).

49. Grand Jury XXIII Report, *supra* note 27, at 1.

50. *Id.*

51. *See generally id.*



Stigmatizing images of people living in poverty are illustrated by—indeed, magnified through—images of poor women in need of reproductive care. The Gosnell case illustrates the deeply troubling implications of limiting access to reproductive health care for poor women in the United States.<sup>52</sup> The perception that poverty is primarily the consequence of failed personal responsibility and individual laziness is deeply ingrained in American social and political history. Since the nation’s founding, Americans have openly presumed that hard work and responsible choices deter poverty.<sup>53</sup> Benjamin Franklin was explicit about this presumption: “[I]f we are industrious, we shall never starve.”<sup>54</sup> Franklin continued, “Laziness travels so slowly, that [p]overty soon overtakes him.”<sup>55</sup> Such images suggest that those who live in poverty bear responsibility for their socioeconomic status.

That suggestion can be and has been used to excuse, if not justify, the political order’s deprivation of poor people’s control over their lives, including the deprivation of control over their reproductive health care choices.<sup>56</sup> In the United States, a generalized, though often tacit, understanding of poverty as a consequence of personal irresponsibility and laziness merges with images of poor mothers as “bad” mothers.<sup>57</sup> Such images buttress efforts to defund programs that provide reproductive care for low-income women.<sup>58</sup> For the most part, bans on the use of state funds to cover reproductive care affect women eligible for Medicaid and various forms of public assistance.<sup>59</sup> With a few exceptions, federal funds cannot be used to pay for abortions through Medicaid.<sup>60</sup> About seventeen states use state funds to pay for medically necessary abortions for Medicaid beneficiaries.<sup>61</sup> Other states’ Medicaid programs do not

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52. See Miller, *supra* note 27.

53. See *infra* Part V.

54. NEWMAN, *supra* note 24, at 143.

55. *Id.*

56. See *infra* Part V.B.

57. Similar patterns have marked the history of welfare in the U.S. For instance, in the first decades of the twentieth century, employers gave pensions only to “good” mothers—mostly widows.” Molly Ladd-Taylor & Lauri Umansky, *Introduction* to “BAD” MOTHERS: THE POLITICS OF BLAME IN TWENTIETH-CENTURY AMERICA, *supra* note 23, at 1, 12.

58. See *infra* Part IV.B–D (describing laws defunding abortion and contraception for low-income people).

59. See *infra* note 103 and accompanying text (considering the Hyde amendment); see also *infra* notes 206–10, 223–30 and accompanying text (considering H.R. 3 and the Pence Amendment).

60. See *infra* note 103 and accompanying text.

61. KAISER FAMILY FOUND., STATE FUNDING OF ABORTIONS UNDER MEDICAID (2011), *available* at <http://www.statehealthfacts.org/comparetable.jsp?cat=10&ind=458>.

cover abortions except in cases of rape, incest, or risk of death for the pregnant woman.<sup>62</sup>

Poor women bear burdensome consequences due to the lack of public funding for their reproductive care. Good reproductive health care is simply beyond the reach of many poor women.<sup>63</sup> Consequently, the stigma that poverty imposes on poor women is intensified by images of women unable to control their reproductive and sexual lives. These images facilitate negative characterizations of poor women as bad mothers. Such characterizations, in turn, reinforce attributing blame for the poverty and ill-health of poor women to the women themselves. Society thus absolves itself of responsibility for their poverty and accordingly justifies the state's lack of support for the reproductive care of poor women.<sup>64</sup>

Between *Roe v. Wade*,<sup>65</sup> decided in 1973, and the end of the twentieth century, a number of shifts in law and social perspective diminished *Roe*'s protection of the right to abortion for poor women. *Roe* offered reproductive choice to all women and addressed abortion as a medical matter.<sup>66</sup> Developments during the subsequent decade—in particular the Hyde Amendment, which banned the use of federal funds to pay for most Medicaid abortion<sup>67</sup>—seemed aimed at demedicalizing abortion and shaping it as a right accessible only to middle- and upper-class women.<sup>68</sup> In effect, as society and the law have leaned toward limiting or banning abortion, the procedure itself has increasingly been dissociated from regular medical care.<sup>69</sup>

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62. *Id.* South Dakota's Medicaid system covers abortion only when necessary to protect the pregnant woman's life, and in the District of Columbia, Medicaid does not cover abortions. *Id.*

63. See *Unintended Pregnancies a Sign of the Times*, L.A. TIMES, May 7, 2009, [http://latimesblogs.latimes.com/booster\\_shots/2009/05/unintended-pregnancies-a-sign-of-the-times.html](http://latimesblogs.latimes.com/booster_shots/2009/05/unintended-pregnancies-a-sign-of-the-times.html).

64. See Pollitt, *supra* note 23, at 288–89.

65. *Roe v. Wade*, 410 U.S. 113 (1973).

66. *Id.* at 165–66 (“[T]he right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention . . . . Up to those points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician.”).

67. Passed in 1976, the Hyde Amendment has been renewed each year since that time. JESSICA ARONS & MADINA AGÉNOR, SEPARATE AND UNEQUAL: THE HYDE AMENDMENT AND WOMEN OF COLOR, CENTER FOR AMERICAN PROGRESS 1, 7 (2010), available at [http://www.americanprogress.org/issues/2010/12/pdf/hyde\\_amendment.pdf](http://www.americanprogress.org/issues/2010/12/pdf/hyde_amendment.pdf). The original version of the Amendment is Departments of Labor and Health, Education, and Welfare Appropriations Act, Pub. L. No. 94-439, § 209, 90 Stat. 1434 (1976). The 2010 version of the Amendment is Consolidated Appropriations Act, 2010, Pub. L. No. 111-117, Division D, Title V, General Provisions, § 507, 123 Stat. 3034, 3280 (2009). See *infra* note 103 and accompanying text for further information regarding the history and changing restrictions of the Amendment; see also MELODY ROSE, SAFE, LEGAL, AND UNAVAILABLE? 130–31 (2007).

68. Poor women continued to have abortions after the Hyde Amendment, but the burden on them increased enormously. See *infra* notes 125–29 and accompanying text.

69. See *infra* notes 121–24 and accompanying text.

Also, during the last decade of the twentieth century, social and legal shifts—in particular, shifts in the dimensions of the nation’s welfare system—reflected a presumption that mothers on welfare were on public assistance because they had made bad choices and therefore were likely bad mothers. These presumptions were concretized in images of the “welfare mother” and the “welfare queen”—women on public assistance portrayed as “cheat[ing] the system.”<sup>70</sup> Legal efforts to develop “welfare caps” or “child exclusion” programs exemplify the consequences of such conclusions about poor women.<sup>71</sup> These programs preclude benefits for women who have additional children while receiving public assistance.<sup>72</sup>

As abortion was demedicalized, it was simultaneously transformed into a consumer right—available to those able to afford it. That shift was cemented by the Supreme Court’s decision in *Harris v. McRae*,<sup>73</sup> which upheld the constitutionality of the Hyde Amendment. Defunding Medicaid abortions<sup>74</sup> stigmatized poor women generally, and poor pregnant women specifically, by limiting their reproductive choices.<sup>75</sup> For middle-class women, the incidents of reproduction—whether to get pregnant, when to have a child, when to end a pregnancy, and even whether to pay third parties to participate in the reproductive process—are matters of individual choice.<sup>76</sup> As described by Rickie Solinger, poor women are consistently deprived of the same choices:

In the minds of many people, legitimate pregnancies have now become a class privilege, reserved for women with resources. Other women—those without resources—who get pregnant and stay pregnant are often regarded as making bad choices. As middle-class women have claimed reproductive privacy for themselves . . . they have too frequently allowed the fertile bodies of women without

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In a report about Kermit Gosnell’s Women’s Medical Society (described *supra* in Part II.A), Katha Pollitt quoted a spokesperson for the Women’s Law Project in Pennsylvania and noted that Pennsylvania lawmakers’ attention focused on banning abortion rather than on “abortion as health care.” Katha Pollitt, *Dr. Kermit Gosnell’s Horror Show*, THE NATION, Jan. 27, 2011, <http://www.thenation.com/article/158089/dr-kermit-gosnells-horror-show> (quoting Carol Tracy of the Women’s Law Project).

70. Kelly, *supra* note 21, at 78 (quoting RICKIE SOLINGER, BEGGARS AND CHOOSERS: HOW THE POLITICS OF CHOICE SHAPES ADOPTION, ABORTION, AND WELFARE IN THE UNITED STATES 155 (2001)).

71. See *infra* Part III.D (considering welfare reform during the 1990s).

72. The programs reflect and reinforce negative images of low-income mothers generally and, even more often, of low-income Black mothers specifically. Kelly, *supra* note 21, at 78.

73. *Harris v. McRae*, 448 U.S. 297 (1980) (validating the Hyde Amendment, which precluded use of federal funds for “medically necessary” abortions through Medicaid).

74. See *supra* note 67 (describing the Hyde Amendment).

75. RICKIE SOLINGER, PREGNANCY AND POWER: A SHORT HISTORY OF REPRODUCTIVE POLITICS IN AMERICA 201 (2005).

76. *Id.* at 217.

private resources to be assessed and condemned in the public sphere.<sup>77</sup>

### III. LEGAL AND SOCIAL HISTORY: POOR WOMEN, ABORTION, FAMILY PLANNING, AND WELFARE IN THE LATE-TWENTIETH CENTURY

This Part describes efforts to deprive poor women of coverage for good reproductive health care. A host of twentieth and twenty-first century reproductive policies—from funding limits on Medicaid abortions to policies encouraging or even coercing women to undergo sterilization<sup>78</sup>—has consistently limited the reproductive choices of poor women. Women without private resources who are denied state-funded reproductive care are compelled to have children they do not want or to spend money they do not have. And poor women, urged to have fewer children by state policies that limit welfare benefits or otherwise discourage reproduction, bear fewer children than they would choose or experience a harder time supporting the children they do have.<sup>79</sup>

Section A provides a short summary of the Supreme Court's recognition of the constitutional right to birth control and abortion during the 1960s and 1970s. Sections B and C describe the processes through which the rights to abortion and family planning (including contraception) were whittled away during the last two decades of the twentieth century, especially for low-income women. Section D of this Part explains how the 1990s welfare reform exacerbated the consequences of the federal government's defunding abortion and limiting funding for family planning.

#### *A. A Right to Contraception and Abortion and the Limits of that Right: Griswold, Eisenstadt, Roe, and Casey*

This section discusses social and legal developments regarding women's reproductive care that have affected poor women in particular. It begins by reviewing Supreme Court decisions that have addressed—and sometimes guaranteed—the right to use contraception and the right to abortion. The cases span the period between the 1965 decision, *Griswold v. Connecticut*,<sup>80</sup> and the 1992 decision, *Planned Parenthood of*

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77. *Id.*

78. See Patrick J. Ryan, "Six Blacks from Home": *Childhood, Motherhood, and Eugenics in America*, 19 J. POL'Y HIST. 253 (2007) (considering the history of eugenics in the United States throughout the twentieth century).

79. See *id.* Ryan illustrates the continuing force of eugenics policies into the second half of the twentieth century by noting a 1972 recommendation of California's welfare advisory board "that women who gave birth to more than two children while unmarried be declared unfit parents and be required to relinquish any subsequent children to the state." *Id.* at 274.

80. *Griswold v. Connecticut*, 381 U.S. 479 (1965).

*Southeastern Pennsylvania v. Casey*.<sup>81</sup> The section then examines limits on the right to abortion and contraception that resulted from restrictions on the use of Medicaid funding and from public-funding cuts for other forms of reproductive care.

In 1965, *Griswold* invalidated a Connecticut statute that criminalized the use of birth control as well as counseling or assisting others in that use.<sup>82</sup> The Court grounded its decision in the “penumbras” surrounding “specific guarantees in the Bill of Rights.”<sup>83</sup> The case specifically granted the right to use birth control to married couples, and the decision rested on a traditional vision of the spousal relationship as the virtual exemplar of a “private” relationship.<sup>84</sup>

Seven years later, in *Eisenstadt v. Baird*, the Court broadened *Griswold*’s holding to include unmarried people.<sup>85</sup> In *Eisenstadt*, the Court invoked the Equal Protection Clause of the Fourteenth Amendment and concluded that “[i]f under *Griswold* the distribution of contraception to married persons cannot be prohibited, a ban on distribution to unmarried persons would be equally impermissible.”<sup>86</sup> The decision was particularly significant because it abandoned a vision of families as communal wholes and replaced it with a vision in which family members became individuals, similar to actors in the commercial marketplace. The right to contraception defined in *Eisenstadt* is a right to autonomous control of one’s own reproductive decisions. In significant part, that vision remains in place. But it has been explicitly limited in the context of abortion and implicitly limited in reference to poor women.<sup>87</sup>

One year after *Eisenstadt*, in *Roe*, the Court entertained a case that involved abortion, rather than contraception, and the reproductive rights of women in particular.<sup>88</sup> The Court’s decision has been widely interpreted, applauded, criticized, dissected, and limited by subsequent cases. *Roe* involved a challenge to a state statute that criminalized abortion (except when necessary to save the life of the pregnant woman). The Court invalidated the statute in light of a woman’s “right to privacy”—a right which the Court located in the “Fourteenth Amendment’s concept of personal liberty and restrictions on state action” or, following the lower court’s determination, in the “Ninth Amendment’s reservation of rights

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81. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992) (joint opinion).

82. *Griswold*, 381 U.S. at 482–83.

83. *Id.* at 484.

84. *Id.* at 495.

85. *Eisenstadt v. Baird*, 405 U.S. 438 (1972).

86. *Id.* at 453.

87. *See infra* notes 128–30 and accompanying text.

88. *Roe v. Wade*, 410 U.S. 113 (1973).

to the people.”<sup>89</sup> The Court elaborated on, and in part limited, the right through reference to a trimester framework. During the first trimester, the Court left the right to abortion to “the medical judgment of the pregnant woman’s attending physician.”<sup>90</sup> *Roe* provided that by the third trimester of a pregnancy (a period equated with fetal viability), states could limit the right to abortion “except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.”<sup>91</sup>

The decades following the Court’s decision in *Roe* were characterized by continuing efforts to limit or undermine the right it granted. In 1992, the Supreme Court issued its most significant statement subsequent to *Roe* about the constitutional right to abortion. In *Casey*, the Court realigned the contours of the right to abortion but did not, as many thought might happen, eviscerate that right. *Casey* involved a challenge to a Pennsylvania statute that limited the right to abortion by mandating, among other things, waiting periods, a requirement that the husband of a married pregnant woman be notified of her intent to abort, and that a woman seeking an abortion be given specific information before consenting to the procedure.<sup>92</sup> The Court expressly preserved the “constitutional liberty of the woman to have some freedom to terminate her pregnancy,” but it upheld most of the statute’s provisions.<sup>93</sup> Significantly, the Court replaced the trimester framework that governed *Roe*, devising one with two stages separated by the point of fetal viability.<sup>94</sup> Further, the Court justified state interference with the right to abortion unless that interference imposed an “undue burden” on the pregnant woman.<sup>95</sup> The Court defined that burden as “a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.”<sup>96</sup>

In sum, the cases that followed *Roe* reshaped, reimagined, and in significant part, limited a woman’s right to abortion. *Casey* altered *Roe*’s approach but preserved the basic right. Other abortion cases decided in *Roe*’s wake concerned a variety of specific issues, including the right of a minor to have abortion,<sup>97</sup> limits on the type of abortion that women and

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89. *Id.* at 153.

90. *Id.* at 164.

91. *Id.* at 164–65.

92. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 844 (1992) (joint opinion).

93. *Id.* at 869. The Court invalidated a provision in the state statute that required spousal notification. *Id.* at 898.

94. *Id.* at 870–71.

95. *Id.* at 877.

96. *Id.*

97. *See, e.g., Bellotti v. Baird*, 443 U.S. 622 (1979) (requiring a judicial bypass option for a minor in a state with a parental consent requirement for the minor to have an abortion).

their physicians may choose,<sup>98</sup> and the right to public funding for abortion.<sup>99</sup> The next section considers abortion jurisprudence about this last matter. It exclusively focuses on the legal changes and proposed changes that diminish the value of the right to abortion for low-income women in particular.

### B. The Hyde Amendment and *Harris v. McRae*

Soon after the Court’s 1973 decision in *Roe*, members of Congress with disparate interests joined together to prohibit the use of federal funding for abortions through Medicaid.<sup>100</sup> The group included some straightforward abortion opponents, those concerned with imposing limits on federal spending, and others who sought political gain by siding with abortion opponents.<sup>101</sup> The result was the Hyde Amendment,<sup>102</sup> named for Representative Henry Hyde of Illinois, an original sponsor of the Amendment and a staunch opponent of abortion. The Amendment, first promulgated in 1976, restricts the use of federal funds for abortions obtained through Medicaid.<sup>103</sup> Congress has reenacted it every year since

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98. See, e.g., *Gonzales v. Carhart*, 550 U.S. 124 (2007) (validating the Partial-Birth Abortion Ban Act of 2003).

99. See, e.g., *Harris v. McRae*, 448 U.S. 297 (1980) (upholding the federal law banning use of federal funds for abortions through Medicaid); see also *infra* notes 111–14 and accompanying text (considering *McRae*).

100. See *infra* note 103 and accompanying text (discussing the Hyde Amendment).

101. ROSE, *supra* note 67, at 129.

102. Consolidated Appropriations Act of 2010, Pub. L. No. 111-117, Division D, Title V, General Provisions, § 507, 123 Stat. 3034, 3280 (2009). The original version of the Hyde Amendment, passed in 1976, is Departments of Labor and Health, Education, and Welfare Appropriations Act, Pub. L. No. 94-439, § 209, 90 Stat. 1434 (1976). The Amendment is a rider attached to annual Medicaid appropriations bills.

103. Departments of Labor and Health, Education, and Welfare Appropriations Act, § 209.

The Hyde Amendment’s limitations on federal funds for abortion were first implemented on August 4, 1977, when a New York federal district court’s injunction was lifted in response to a Supreme Court ruling. See Jon F. Merz, Catherine A. Jackson & Jacob A. Klerman, *A Review of Abortion Policy: Legality, Medicaid Funding, and Parental Involvement, 1967–1994*, 17 WOMEN’S RTS. L. REP. 1, 7–8 (1995). The Amendment was enjoined for several months in 1980 until the Supreme Court validated it. *Id.* (discussing the immediate postenactment history of the Amendment, including *McRae*, 448 U.S. 297, and the Supreme Court’s subsequent decline of a rehearing on September 19, 1980, when funding was again restricted). See also Willard Cates, Jr., *The Hyde Amendment in Action: How Did the Restriction of Federal Funds for Abortion Affect Low-Income Women?*, 246 J. AM. MED. ASS’N 1109 (1981).

The original version of the Hyde Amendment passed in 1976 provided an exception only for abortions required to save the life of the pregnant woman. ROSE, *supra* note 67, at 129. Rose outlined changes in exceptions to the Hyde Amendment during subsequent years. *Id.* at 130–31. Since then, additional exceptions (e.g., in cases of rape or incest) were added, reshaped, and eliminated, and the matter of appropriate exceptions has been subject to continuing debate. In 1977, Congress expanded exceptions to include cases of rape and incest and cases in which the health of the pregnant woman was threatened. *Id.* Then in 1979, the exception to safeguard a woman’s health was removed from the Amendment. *Id.* at 130. A 1981 change in the Hyde Amendment—eliminating exceptions for

1976, as part of the process of appropriations for the Department of Health, Education, and Welfare (now called the Department of Health and Human Services) or by a joint resolution.<sup>104</sup>

The Hyde Amendment served a number of ideological ends. Similar to other post-*Roe* attempts by lawmakers to limit abortion,<sup>105</sup> the Hyde Amendment allowed members of Congress to satisfy a powerful, vocal pro-life constituency while protecting access to abortion for middle- and upper-class women.<sup>106</sup> The Amendment served pro-life adherents' interest in limiting or precluding abortion altogether. It also reflected the notions that poor people lack individual responsibility<sup>107</sup> and that poor women—and poor pregnant women, in particular—are prone to irresponsible behavior.<sup>108</sup> Defunding abortions for poor women does not save money, and thus, proponents cannot justify it on budgetary grounds.<sup>109</sup> In fact, the federal government's refusal to pay for Medicaid abortions is expensive.<sup>110</sup> Justification for the refusal seems to rest on a pro-life position or on disdain for poor women who become pregnant unintentionally.

The Supreme Court upheld the Hyde Amendment in *McRae*.<sup>111</sup> In a 5–4 decision, the Court concluded that wide restrictions on the use of federal funds to support Medicaid abortions did not violate a poor woman's right to an abortion.<sup>112</sup> The Court rejected the plaintiffs' claim that the Amendment interfered with their Fourteenth Amendment right to liberty, as delineated in *Roe* and subsequent cases.<sup>113</sup> In effect, the Court proclaimed that poor women do not have the same options as women

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rape and incest—reflected newly elected President Reagan's pro-life platform. *Id.* at 131. After Bill Clinton's election in 1992, exceptions for cases involving pregnancies resulting from rape or incest were reinserted. *Id.* The 2009 version, promulgated during the first year of Barack Obama's presidency, included exceptions for rape, incest, and endangerment to the woman's life. Consolidated Appropriations Act of 2010, § 507.

104. *McRae*, 448 U.S. at 302; ARONS & AGÉNOR, *supra* note 67, at 7.

105. Among these are state laws requiring a pregnant minor to inform her parents before aborting a pregnancy. *See, e.g.*, *Bellotti v. Baird*, 443 U.S. 622 (1979) (considering a challenge to a Massachusetts statute requiring pregnant minors seeking abortions to obtain consent from both parents, with an option to seek judicial approval for an abortion if parental consent was not forthcoming, and requiring a judicial "bypass" option to allow minor girls to go to court without informing their parents).

106. DEBORAH R. MCFARLANE & KENNETH J. MEIER, *THE POLITICS OF FERTILITY CONTROL* 9 (2001).

107. This notion has been widely accepted in the United States since the nation's founding. *See supra* note 24 and accompanying text (quoting Benjamin Franklin).

108. MCFARLANE & MEIER, *supra* note 106, at 11–12.

109. *See infra* notes 233–39 and accompanying text.

110. MCFARLANE & MEIER, *supra* note 106, at 12.

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

112. *Id.*

113. *Id.* at 312.



with resources but that the government is not responsible for their poverty. Consequently, defunding Medicaid abortions does not interfere with the constitutional rights of a poor, pregnant woman anxious to terminate her pregnancy. Justice Stewart, writing for the Court, explained:

[R]egardless 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 . . . . [A]lthough 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. Indigence 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 of her indigence. Although Congress has opted to subsidize medically necessary services generally [through the Medicaid program], but not certain medically necessary abortions, the fact remains that the Hyde Amendment leaves an indigent woman with at least the same range of choice 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*.<sup>114</sup>

Rhetoric surrounding limitations imposed by the Hyde Amendment reinvigorated an ideology that presumes responsibility for poverty lies with bad choices made by those who live in poverty. For instance, Senator Orrin Hatch (R.-Utah) invoked the irresponsibility of a poor woman who failed to save enough money to pay for a wanted abortion: “[T]here is nothing to prevent [a poor woman] . . . from either exercising increased self-restraint, or from sacrificing on some item or other for a month or two to afford [her] own abortion.”<sup>115</sup> Often enough, however, Hatch’s advice that poor women in need of an abortion might responsibly “sacrifice[] on some item” has been belied by reality.<sup>116</sup>

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114. *Id.* at 316–17.

115. SOLINGER, *supra* note 75, at 202 (citing and quoting from 124 CONG. REC. 31, 900 (1978)).

116. See *infra* notes 211–13 and accompanying text.

In the same year that the Supreme Court decided *McRae*, a federal district court in Connecticut reported<sup>117</sup> that more than a third of poor women in Connecticut in need of “medically necessary” abortions were “unable to raise the funds” required to pay for them “and were thus forced to carry their abnormal pregnancies to term.”<sup>118</sup> Even more, many poor women who have managed to locate the necessary funds have been unable to do so without a lapse in time between the decision to end the pregnancy and the abortion. The later an abortion is performed, the greater the risk and the cost.<sup>119</sup> The district court in *Women’s Health Services, Inc. v. Maher* reported some of the consequences of the Hyde Amendment for poor women:

[Those who did] obtain funds to pay for therapeutic abortions [did that] only with some sacrifice—not paying rent or utility bills, pawning household goods, diverting food and clothing money, or journeying to another state to obtain lower rates or fraudulently use a relative’s insurance policy. In a few cases, some patients were driven to theft.<sup>120</sup>

In effect, the Hyde Amendment and *McRae*<sup>121</sup> facilitated a process that recast abortion as a commercial good rather than a medical procedure. In subsequent years, legislatures further demedicalized abortion for all women by displacing physicians’ judgments with laws that dictated what abortion procedures could be used in practice,<sup>122</sup> and by regulating decisions that resulted in treating abortion facilities differently than other health care clinics.<sup>123</sup> After *Roe*, many abortion facilities were physically separated from other health care services. This pattern further removed abortion from the world of mainstream medicine.<sup>124</sup>

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117. *Women’s Health Servs., Inc. v. Maher*, 482 F. Supp. 725, 731 (D. Conn. 1980), *vacated*, 636 F.2d 23 (2d Cir. 1980) (concluding that the government has no constitutional obligation to pay for abortions for poor women).

118. *Id.*

119. See Dehlendorf & Weitz, *supra* note 18, at 416. Delay is especially consequential for health and cost if the procedure is pushed into the second trimester. SOLINGER, *supra* note 75, at 202 (reporting that delaying abortion carries a significant risk). The risk of mortalities related to abortion increases each week after eight weeks of gestation. Dehlendorf & Weitz, *supra* note 18, at 417. Still, carrying a pregnancy to term is more risky than having an abortion “regardless of the gestational age.” *Id.*

120. *Mahe*, 482 F. Supp. at 731 n.9 (citing Defendant’s Ex. B-1, Transcript of Hearing, at 61–66, 96).

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

122. See *Gonzalez v. Carhart*, 550 U.S. 124 (2007) (upholding the Partial-Birth Abortion Ban Act of 2003, a federal law identifying illegal abortion procedures and thus displacing physician judgment).

123. Bottum, *supra* note 30.

124. This pattern has also facilitated picketing abortion clinics and has thus furthered the stigmatization of all women seeking abortions. Alison Norris et al., *Abortion Stigma: A Reconceptual-*

The consequences of abortion’s demedicalization have been hardest on poor women without coverage for abortion. They more often than not depend on public clinics for care. They wait longer before seeking an abortion provider than they would if abortions were available through Medicaid. And they are more likely to use substandard providers than women with private resources.<sup>125</sup>

Some states provide state funding for Medicaid abortions.<sup>126</sup> In the states that do not, most poor women seeking an abortion are often compelled to postpone the procedure while seeking money to pay for it.<sup>127</sup> The postponement increases the risks and costs of the procedure. A second-trimester abortion costs significantly more than a first-trimester abortion.<sup>128</sup>

Moreover, cuts in public funding for family-planning services have seriously exacerbated the burden that the Hyde Amendment places on poor women.<sup>129</sup> Those cuts began a decade after promulgation of Title X, which funded reproductive health care at a network of clinics throughout the country. Cuts have followed every decade since.<sup>130</sup>

### C. Family Planning

The Supreme Court found a constitutional right to contraception in 1965 in *Griswold*.<sup>131</sup> In the aftermath of *Griswold* and *Eisenstadt*<sup>132</sup> in 1972, birth control became legally available everywhere in the U.S.<sup>133</sup> In

zation of Constituents, Causes, and Consequences, 21 WOMEN’S HEALTH ISSUES S49, S52 (2011). See also *infra* note 145 (discussing Title X regulation changes).

125. See *supra* note 42 and accompanying text. By the first decade of the twenty-first century, little had changed for poor women seeking abortions since Congress first promulgated the Hyde Amendment in the late 1970s.

126. KAISER FAMILY FOUND., *supra* note 61.

127. Heather D. Boonstra, *The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States*, 10 GUTTMACHER POL’Y REV. 12, 14–15 (2007) (“Poor women take up to three weeks longer than other women to obtain an abortion.”); see also Marc Kaufman, *Unwanted Pregnancies Rise for Poor Women*, WASH. POST, May 5, 2006, <http://www.washingtonpost.com/wp-dyn/content/article/2006/05/04/AR2006050400820.html> (reporting that on average poor women seeking abortions are delayed six days more than women with greater resources).

128. See Dehlendorf & Weitz, *supra* note 18, at 416; see also Boonstra, *supra* note 127, at 15 (reporting that in 2001 an abortion obtained at ten weeks gestation cost \$370 on average, by fourteen weeks the cost was \$650, and by twenty weeks it was \$1,042).

129. See *infra* Part IV.C.

130. ROSE, *supra* note 67, at 134–35, 176.

131. *Griswold v. Connecticut*, 381 U.S. 479 (1965).

132. *Eisenstadt v. Baird*, 405 U.S. 438 (1972).

133. Before *Griswold*, contraception was available, but not legally, in states that prohibited the use or sale of contraception. For instance, in *Poe v. Ullman*, 367 U.S. 497 (1961), a case challenging Connecticut’s birth control statute, the Supreme Court identified only one prosecution pursuant to the law during a period of many decades. The Court thus dismissed the case because it was not ripe. *Id.* The Court noted that many Connecticut pharmacies sold contraception despite the state. *Id.* at 502.

the same year that the Court decided *Griswold*, President Johnson's State of the Union address voiced concern about increases in population, and for the first time, the federal government funded some contraceptive care through Johnson's War on Poverty.<sup>134</sup> Five years after Johnson's expression of concern and the Supreme Court's decision in *Griswold*, Congress passed Title X of the Public Health Service Act with bipartisan support.<sup>135</sup> Title X offered federal funding for comprehensive family-planning services.<sup>136</sup>

When President Nixon signed the bill, he promised that no woman would be deprived of family planning "because of her economic condition."<sup>137</sup> The law provided for federal and state funding of clinics that offered family-planning services.<sup>138</sup> As a result, low-income women gained access to contraceptives<sup>139</sup> and to "preventive health services," including screening for cervical and breast cancers, testing for sexually transmitted diseases, pregnancy diagnosis and counseling, and later HIV counseling, testing, and referral.<sup>140</sup> Title X precludes the use of federal funds for abortions, and it prohibits the distribution of federal funds to any program providing abortion services.<sup>141</sup>

Over the years, government regulations and administrative interpretations of Title X have changed.<sup>142</sup> At first, administrative practice permitted those receiving the funds to counsel clients about abortion and to refer them to abortion providers.<sup>143</sup> Later, such counseling and referral were even required.<sup>144</sup> In 1988, however, new regulations promulgated by the Public Health Service prohibited any grantee from engaging in abortion counseling or referrals for abortions.<sup>145</sup> The 1988 regulations

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134. GORDON, *supra* note 5, at 289.

135. *Id.*

136. Family Planning Services and Population Research Act of 1970, Pub. L. No. 91-572, 84 Stat. 1504 (codified as amended at 42 U.S.C. §§ 300-300a-6 (2006)).

137. GORDON, *supra* note 5, at 289 (quoting MARTHA C. WARD, POOR WOMEN, POWERFUL MEN: AMERICA'S GREAT EXPERIMENT IN FAMILY PLANNING 68 (1986)).

138. 42 U.S.C. §§ 300-300a-6.

139. *Title X Family Planning*, U.S. DEP'T OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/opa/familyplanning/index.html> (last visited June 30, 2011).

140. *Id.*

141. 42 U.S.C. § 300a-6.

142. *State of N.Y. v. Sullivan*, 889 F.2d 401, 404-06 (2nd Cir. 1989).

143. *Id.* (citing U.S. DEP'T OF HEALTH, EDUC. & WELFARE, PROGRAM INCENTIVES FOR PROJECT GRANTS FOR FAMILY PLANNING SERVICES (1976) and U.S. DEP'T OF HEALTH & HUMAN SERVICES, PROGRAM GUIDELINES FOR PROJECT GRANTS FOR FAMILY PLANNING SERVICES § 8.6 (1981)).

144. *Id.*

145. 42 C.F.R. § 59.9 (1988); see also Scott E. Johnson, *Rust v. Sullivan: The Supreme Court Upholds the Title X Abortion-Counseling Gag Rule*, 94 W. VA. L. REV. 209, 211-15 (1991); Alexandra A. E. Shapiro, Note, *Title X, the Abortion Debate, and the First Amendment*, 90 COLUM. L. REV. 1737, 1739-40 (1990). "Gag rule" refers to the label opponents of the new regulations gave them,

required an organization receiving Title X funds to ensure that any use of those funds would be physically and financially separate from prohibited activities related to abortion.<sup>146</sup>

The broad array of family-planning services promised by Title X has not always been actualized. Although every state developed at least one Title X clinic, some states have relied far less heavily on Title X funds than others.<sup>147</sup> Even in those states that have favored the use of public funds for contraceptive services, approval has sometimes required the invocation of themes that appealed to conservative—and even to racist<sup>148</sup>—state legislators.

Progressives in Louisiana concluded that they could succeed in creating family-planning clinics for poor women only by relying on racist claims that “family planning would lower welfare costs as well as the birth rate among [B]lacks.”<sup>149</sup> In that context, it is unsurprising that poor women—and especially poor Black women in Louisiana and other

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“since they ‘gagged’ doctors with respect to their ability to discuss abortion with their patients.” Johnson, *supra*, at n.18.

The Department of Health and Human Services established the new regulations in response to a 1987 request by then President Ronald Reagan. *Id.* at 212. The Supreme Court ultimately upheld, among other provisions in the new regulations, the government’s conditioning federal funds for family planning on the stipulation that recipients not offer counseling about or referrals for abortion. *Rust v. Sullivan*, 500 U.S. 173 (1992). Finding ambiguous both the plain language and legislative history of the Title X statute, the Court deferred to the Secretary of Health and Human Services’ new interpretation, even if it represented a “sharp break from the Secretary’s prior construction of the statute.” *Id.* at 186. The Court found the Secretary’s justifications for the change sufficient. Among the Court’s justifications was the Secretary’s “determin[ation] that the new regulations are more in keeping with the original intent of the statute, are justified by client experience under the prior policy, and are supported by a shift in attitude against the ‘elimination of unborn children by abortion.’” *Id.* at 187. Second Circuit Judge Kears, dissenting in the case below, noted that there was no suggestion that the “Secretary’s about-face” was needed, and observed that “at oral argument of this case in the district court, the Secretary admitted that his new regulations were the result of a shift in the political climate.” *Sullivan*, 889 F.2d at 418.

In his dissent in *Rust v. Sullivan*, Supreme Court Justice Blackmun stated that “[t]he manipulation of the doctor-patient dialogue achieved through the Secretary’s regulations is clearly an effort ‘to deter a woman from making a decision that, with her physician, is hers to make.’ . . . As such it violates the Fifth Amendment.” 500 U.S. at 219 (internal citation omitted). He also stated, “The denial of [the freedom to choose] is not a consequence of poverty but of the Government’s ill-intentioned distortion of information it has chosen to provide.” *Id.* at 217.

146. 53 Fed. Reg. 2,922, 2,945 (Feb. 2, 1988) (codified at 42 C.F.R. § 59.9); *see also Rust*, 500 U.S. 173 (upholding the regulations).

147. MCFARLANE & MEIER, *supra* note 106, at 80–81 (noting that in Arkansas 44% of public funding for contraceptive and other family-planning services came from Title X funds; in New Hampshire, however, the percentage was much lower (only 16%)).

148. GORDON, *supra* note 5, at 290 (quoting racist state legislators as having openly approved of providing birth control to Black women for eugenic ends).

149. *Id.* at 289.

Southern states with similar conservative views—have suspected the motives of those running birth-control clinics in their communities.<sup>150</sup>

Although Title X was an impressive effort to give poor women more control over their reproductive lives, that aim was deflected almost from the start. Soon after implementing Title X programs, the federal government limited their funding.<sup>151</sup> Even more, eugenic undertones haunted the actualization of Title X family-planning clinics with a disproportionate placement of clinics in communities of color.<sup>152</sup> Further, the clinics' reliance on long-term forms of birth control (e.g., IUDs and sterilization) instead of short-term forms (e.g., diaphragms or the pill) may well have diminished rather than strengthened the reproductive control of poor women.<sup>153</sup>

Public support moved even further away from the reproductive needs of poor women during the 1990s.<sup>154</sup> Many legal measures that deprived poor women of reproductive control were enacted. For example, some states paid poor women not to have children (e.g., offering cash to poor women for using long-term contraception) or undermined their financial security if they had additional children (e.g., family caps).<sup>155</sup> Such measures reflected a deeply negative sentiment about poor women's reproductive lives embedded in the decade's welfare reform efforts.<sup>156</sup> As Rickie Solinger argued:

[In the 1990s], judges and legislators defined poor women's reproductive behavior as both insubordinate (resistant to authority) and expensive. The valuable reproduction of middle-class women, whether inside or outside of marriage, whether subordinate or insubordinate, has been subsidized by tax laws that allowed deductions for dependent children, child care, mortgage, and other family expenses. But politicians worked hard in the 1990s to "end welfare as we know it," by which many of them meant to stop "rewarding" poor women for having babies . . . .<sup>157</sup>

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150. *Id.* at 290. Even so, the clinics successfully provide basic reproductive care for poor women and reduced the mortality rate of infants and mothers. *Id.* (reporting that in Louisiana in the first half of the 1970s, infant mortality fell by 26% and maternity mortality fell by over 50%).

151. *Id.* at 291.

152. *Id.* at 290.

153. *Id.*

154. See *infra* notes 161–71 and accompanying text (discussing the Personal Responsibility and Work Opportunity Reconciliation Act of 1996).

155. SOLINGER, *supra* note 75, at 223.

156. See *infra* notes 172–75.

157. SOLINGER, *supra* note 75, at 223 (quoting Linda McClain, "Irresponsible" Reproduction, 47 HASTINGS L.J. 339, 415 (1996)).

At that time, Medicaid eligibility and health care insurance declined for women of childbearing age.<sup>158</sup> During the same decade, abortion among poor women increased.<sup>159</sup> Even a decade later, Solinger reported that "the poorest women in the United States have the worst access to birth control and the highest abortion rates."<sup>160</sup> That inverse correlation is likely not accidental, and shifts in welfare laws in the 1990s probably exacerbated these consequences. The next section more fully considers the 1990s welfare reform, and the connections between that reform and laws that limit reproductive health care for poor women.

#### *D. Welfare Reform in the Mid-1990s*

A number of intertwined motivations animated the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRA), which reformed the nation's welfare system.<sup>161</sup> The PRA placed startling limits on poor women's reproductive choices. At least some of the justifications for welfare reform at the end of the twentieth century relied on a stereotype of poor, single mothers as responsible for a wide array of social problems, including crime, riots, and poverty.<sup>162</sup> Reform of the nation's welfare system during this period rested on, among other things, an interest in channeling the reproductive lives of poor people.<sup>163</sup> The PRA placed a double bind on poor women who became pregnant unintentionally. Under the new welfare rules described in this section, poor women receiving welfare would in effect become even poorer with the birth of each additional child. But restrictions on the use of federal funding for abortion through Medicaid seemed to encourage more, rather than fewer, births among poor women.<sup>164</sup>

The PRA replaced Aid to Families with Dependent Children<sup>165</sup>—an entitlement program promulgated as part of the Social Security Act of 1936—with a program dependent on block grants to states. The PRA mandated that states use the grants for short-term assistance to poor

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158. *Id.* at 219.

159. *Id.*

160. *Id.*

161. Pub. L. No. 104-193, 110 Stat. 2105 (1996) (codified as amended in scattered sections of 42 U.S.C.).

162. Ladd-Taylor & Umansky, *supra* note 57, at 17.

163. RONALD J. ANGEL, LAURA LEIN & JANE HENRICI, POOR FAMILIES IN AMERICA'S HEALTH CARE CRISIS 14 (2006).

164. Dehlendorf & Weitz, *supra* note 18, at 415, 417.

165. See 45 C.F.R. § 233.20(a)(1)(1996). Aid to Families with Dependent Children (AFDC) guaranteed income support to families who met income eligibility criteria. AFDC did permit states to set benefit levels. See *id.* § 233.20(a)(2). See also Sheryll D. Cashin, *Federalism, Welfare Reform, and the Minority Poor: Accounting for the Tyranny of State Majorities*, 99 COLUM. L. REV. 552, 558 (1999).

families through the Temporary Assistance to Needy Families (TANF) program.<sup>166</sup> Although the PRA gave states significant room to design programs within their boundaries,<sup>167</sup> the new program stressed the importance of work and marriage.<sup>168</sup> The PRA conditioned receipt of welfare on seeking and finding work, and it limited individuals to five years of welfare.<sup>169</sup> The PRA extended states the option to establish the terms of eligibility and the level of benefits offered to welfare recipients.<sup>170</sup> This option included authority to set family caps within a state.<sup>171</sup>

Previously under Aid to Families with Dependent Children, benefit allocation depended on the number of children in that family.<sup>172</sup> Placing family caps on welfare reflected a congressional belief that welfare payments encouraged childbirth among recipients<sup>173</sup> and that family caps would encourage poor women to limit childbearing.<sup>174</sup> By the start of the twenty-first century, two dozen states had promulgated similar rules.<sup>175</sup> But TANF did not provide a mechanism for states or the federal government to determine whether family caps had any effect on rates of reproduction among those receiving benefits through the program.<sup>176</sup> As a result, there is little evidence through which to assess the system's consequences.<sup>177</sup> The evidence that does exist does not support the presumption that family caps limit childbearing among poor women.<sup>178</sup>

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166. Temporary Assistance to Needy Families (TANF), part of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, Title I, § 103(a)(1), 110 Stat. 2105, 2110-13 (codified at 42 U.S.C. §§ 601-617 (1996)). The program limits assistance using federal funds under the program to sixty months in a lifetime. 42 U.S.C. § 608.

167. *Id.* § 601(a).

168. *Id.*

169. *Id.* § 607. The PRA required welfare recipients to engage in acceptable work activities within twenty-four months. The law set a lifetime limit of five years on welfare benefits for any person. *Id.* § 608(a)(7). However, the PRA allowed states to establish a shorter period of time for the receipt of benefits or to provide benefits for a longer period in the event of a family "hardship." Pub. L. No. 104-193, § 103, 408(a)(7)(C). The law, however, provided that exceptions allowing receipt of benefits beyond five years cannot exceed 20% of the state's welfare cases. *Id.* §§ 103, 408(a)(7)(C)(ii). See also Benjamin L. Weiss, *Single Mothers' Equal Right to Parent: A Fourteenth Amendment Defense Against Forced-Labor Welfare "Reform,"* 15 L. & INEQUALITY 215, 217 n.5 (1997).

170. See *supra* note 165.

171. Cashin, *supra* note 165, at 561 n.32.

172. Susan Frellich Appleton, *When Welfare Reforms Promote Abortion: "Personal Responsibility," "Family Values," and the Right to Choose*, 85 GEO. L.J. 155, 159 (1996).

173. GORDON, *supra* note 5, at 351.

174. Diana Romero & Madina Agénor, *US Fertility Prevention as Poverty Prevention*, 19 WOMEN'S HEALTH ISSUES 355, 359 (2009).

175. *Id.* at 356.

176. *Id.*

177. *Id.* at 359.

178. *Id.*



The PRA encouraged the narrative that poor women are unable to control their reproductive lives and are unable to raise their children successfully. Yet, the Act exacerbated the difficulties facing poor women anxious to spend more time with their families, while laws defunding Medicaid abortions made it hard for them to limit births. In further irony, although those who favored family caps when Congress promulgated the PRA were generally opposed to abortion,<sup>179</sup> poor women facing a family cap might consider aborting unintended pregnancies.<sup>180</sup> Perhaps reflecting the general anti-abortion sentiment of those who favored family caps, the PRA created bonuses that states could compete for by limiting births among unmarried women. Before it could qualify for the bonus, a state had to show that its rate of abortion was lower than it had been in 1995.<sup>181</sup> The PRA further required that those receiving welfare benefits find paying work. But that requirement seems to have discouraged child-birth and made abortion a reasonable option for women facing unwanted pregnancies<sup>182</sup>—an option that most family-cap advocates and the law itself disfavored.<sup>183</sup>

Thus, by the end of the twentieth century, the federal government had openly curtailed many of the reproductive health care benefits that the previous two decades had brought to poor women. Lawmakers' comfort with that trend deepened in the first years of the twenty-first century—especially after passage of the Affordable Care Act, as discussed in Part IV.

#### IV. COMPROMISING REPRODUCTIVE HEALTH CARE ONCE MORE: PASSAGE OF THE AFFORDABLE CARE ACT AND ITS AFTERMATH

Even as the nation witnessed the advent of health care reform in 2010, Congress and President Obama agreed to limit reproductive care for poor women under the new law. In particular, they agreed to restrict the use of federal funds for abortion under the Affordable Care Act. The Act<sup>184</sup> is a modest effort at reform insofar as it preserves most of the institutions that shaped American health care coverage before its passage.

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179. Appleton, *supra* note 172, at 85.

180. *Id.* at 168.

181. *Id.* at 175.

182. *Id.* at 167.

183. *Id.* at 157–58.

184. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

But if the law is implemented,<sup>185</sup> it will significantly expand access to health care.<sup>186</sup>

Yet, the Act's passage involved a series of significant compromises that limited the reach of the reform, even with regard to expanding access to care. In large part, the victims of those compromises were poor women. As a result of both negotiations between President Obama and Congress before the Act's passage and congressional backlash after its passage, poor women concerned about receiving an equal right to full reproductive health care did not fare well.<sup>187</sup>

Negotiations between the President and members of the 111th Congress resulted in a compromise that reinforced the demedicalization of abortion. The consequences, as ever, would be felt with particular harshness by poor women. Moreover, less than a year after passage of the Act, the 112th Congress further attempted to cut federal funding for abortion and for family-planning services.

#### A. The Abortion Compromise

By the end of 2009, the House and the Senate had each passed a health care reform bill.<sup>188</sup> Under usual circumstances, differences between the two bills would have been debated and mediated in committee.<sup>189</sup> But a January 2010 special election in Massachusetts to replace deceased Senator Ted Kennedy resulted in the election of Republican

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185. The fate of the law continues to be challenged in courts and in Congress. *See, e.g.*, *Virginia v. Sebelius*, 728 F. Supp. 2d 768 (E.D. Va. 2010) (the invalidating the individual mandate); *Liberity Univ., Inc. v. Geithner*, 753 F. Supp. 2d 611 (W.D. Va. 2010) (upholding the individual mandate and the Affordable Care Act generally); *Florida v. U.S. Dep't of Health & Human Servs.*, 716 F. Supp. 2d 1120 (N.D. Fla. 2010); *Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d 882 (E.D. Mich. 2010) (upholding the individual mandate and the legislation generally). *See also* H.R. 2, 112th Cong. (2011). The House passed H.R. 2 on January 19, 2011. *H.R.2—Repealing the Job-Killing Health Care Law Act*, OPENCONGRESS, <http://www.opencongress.org/bill/112-h2/show>.

186. Among changes most relevant to this Article are the Act's extension of Medicaid to cover Americans earning less than 138% of the federal poverty level and the inclusion of family planning among required "benchmark" services. *See* § 2303(c), 124 Stat. at 295; *see also* Sara Rosenbaum, *The Medicaid Family Planning Coverage Expansion Option*, HEALTHREFORMGPS, Mar. 7, 2011, <http://www.healthreformgps.org/resources/the-medicaid-family-planning-coverage-expansion-option-2/>.

187. *See infra* Part IV.A & B.

188. The political decisions that led to passage of the Affordable Care Act in March 2010 are summarized in greater detail in Janet L. Dolgin & Katherine R. Dieterich, *Social and Legal Debate About the Affordable Care Act*, 80 UMKC L. REV. 45, 78–80 (forthcoming 2011), available at [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1928919](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1928919).

189. Michael B. Leahy, *Despite Massachusetts Vote, Health Care Reform Still Coming*, MASS. EMP. L. LETTER (Mar. 2010), <http://blogs.hrhero.com/hrnews/2010/01/20/massachusetts-election-mean-and-the-future-of-health-care-reform/>.

Scott Brown.<sup>190</sup> Brown’s election deprived Senate Democrats of the sixty seats needed to pass a different version of the health care reform bill.<sup>191</sup> In order to save health care reform, Democrats in the House agreed to pass the bill that had been approved in the Senate (thus avoiding the need for a new Senate vote that was unlikely to succeed in light of Brown’s election).<sup>192</sup>

But disagreement about federal funding for abortion under the Act emerged as a central concern.<sup>193</sup> The Senate had added language to its bill that limited abortion funding, but the language did not satisfy a number of pro-life groups.<sup>194</sup> Negotiations between President Obama and pro-life members of the House resulted in a compromise: Obama agreed to issue an executive order that would preclude the use of federal funds available through the Affordable Care Act to pay for any abortions (except in cases of rape, incest, or threat to the pregnant woman’s life).<sup>195</sup> In short, Obama agreed that if the House accepted the Senate bill, he would restrict abortion funding under the Act through an executive order to be issued immediately after passage of the Act.

The promised executive order read, in part:

Following the recent enactment of the Patient Protection and Affordable Care Act (the “Act”), it is necessary to establish an adequate enforcement mechanism to ensure that Federal funds are not used for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered), consistent with a longstanding Federal statutory restriction that is commonly known as the Hyde Amendment. The purpose of this order is to establish a comprehensive, Government-wide set of policies and procedures to achieve this goal and to make certain that all relevant actors—Federal officials, State officials (including insurance regulators) and

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190. Carolyn Lochhead, *Speaker Pelosi Bets the House on Health Care Reform*, S.F. CHRON., Mar. 21, 2010, [http://articles.sfgate.com/2010-03-21/news/18841154\\_1\\_house-democrats-health-care-parents-policies](http://articles.sfgate.com/2010-03-21/news/18841154_1_house-democrats-health-care-parents-policies).

191. Jack Kelly, *Might a Snub Sink the Health Bill?: The Supreme Court May Not Like the Way It Gets Passed*, PITTSBURGH POST-GAZETTE, Mar. 21, 2010, <http://www.post-gazette.com/pg/10080/1044276-373.stm>.

192. *Id.*; see also Gail Russell Chaddock, *Health Care Reform “Fixes” Pass, But Is Bipartisanship Lost?*, CHRISTIAN SCI. MONITOR, Mar. 26, 2010, <http://www.csmonitor.com/USA/Politics/2010/0326/Healthcare-reform-fixes-pass-but-is-bipartisanship-lost>.

193. Ultimately, the House passed a separate bill that altered a few provisions in the Senate bill; these provisions were especially problematic to a number of House Democrats. The Senate passed this altered bill by relying on a process that required only a simple majority for approval. *Id.*

194. STAFF OF THE WASHINGTON POST, LANDMARK: THE INSIDE STORY OF AMERICA’S NEW HEALTH CARE LAW AND WHAT IT MEANS FOR US ALL 181 (2010).

195. George J. Annas et al., *Women and Children Last—The Predictable Effects of Proposed Federal Funding Cuts*, 364 NEW ENG. J. MED. 1590, 1590 (2011).

health care providers—are aware of their responsibilities, new and old.<sup>196</sup>

In return for President Obama's executive order, a group of seven pro-life members of the House voted for the Senate bill without the addition of more restrictive anti-abortion language in the bill itself.<sup>197</sup> The final House vote on the Senate bill was 219–212.<sup>198</sup>

### *B. The 112th Congress and Poor Women's Reproductive Health Care*

The 112th Congress, elected in November 2010—about eight months after President Obama signed the Affordable Care Act—brought a large Republican majority to the House. It included ninety-six new representatives, eighty-seven of them Republicans.<sup>199</sup> In the Senate, Democrats maintained control but by a smaller margin than in the previous Congress.<sup>200</sup> Many of the Republicans who had vociferously opposed health care reform during the campaign were ultimately elected to Congress.<sup>201</sup> Many of them had run for office on platforms committed to limiting the nation's budget.<sup>202</sup> The 112th Congress wove the two goals together.

The new House began the session with a bill, offered symbolically, to repeal the Affordable Care Act.<sup>203</sup> Then Congress shifted its attention to a series of bills intended to ban coverage for abortion and defund clinics that provided family-planning services to hundreds of thousands of low-income women.<sup>204</sup> The newly elected House prioritized cutting federal funding for reproductive care.<sup>205</sup>

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196. Exec. Order No. 13,535, 75 Fed. Reg. 15,599 (Mar. 24, 2010).

197. George J. Annas, *Perspective: The Real Pro-Life Stance—Health Care Reform and Abortion Funding*, 362 NEW ENG. J. MED. 356 (2010).

198. *Id.*

199. Gail Russell Chaddock, *Michele Bachmann, Rand Paul, and 8 Others Shaking up the New Congress*, CHRISTIAN SCI. MONITOR, Jan. 31, 2011, <http://www.csmonitor.com/USA/2011/0131/Michele-Bachmann-Rand-Paul-and-8-others-shaking-up-the-new-Congress/Rep.-Darrell-Issa-R-of-California>.

200. Mike Wereschagin & Salena Zito, *Frustrated Voters Set Up a Divided American Congress*, PITTSBURGH TRIB. REV., Nov. 7, 2010, [http://www.pittsburghlive.com/x/pittsburghtrib/news/s\\_708103.html](http://www.pittsburghlive.com/x/pittsburghtrib/news/s_708103.html).

201. *See, e.g.*, Glenn Thrush, *GOP Frosh: Where's My Health Care?*, POLITICO (Nov. 15, 2010), <http://www.politico.com/news/stories/1110/45181.html#ixzz15UGVFW42> (discussing newly elected Republican congressman Andy Harris).

202. Karoun Demirjian, *Repeal of Health Care Bill Tops Agenda as GOP Takes Over House*, LAS VEGAS SUN, Jan. 5, 2011, <http://www.lasvegassun.com/news/2011/jan/05/repeal-health-care-bill-crosshairs-gop-takes-over/>.

203. H.R. 2, 112th Cong. (2011).

204. Gail Collins, *The Siege of Planned Parenthood*, N.Y. TIMES, Feb. 4, 2011, <http://www.nytimes.com/2011/02/05/opinion/05collins.html>.

205. *See* Annas et al., *supra* note 195. The House effort to cut abortion funding for poor women extended to women outside the United States. Chris Morris, *House Committee Votes for Interna-*

Anxious to clarify the implications of abortion-funding negotiations between Obama and the 111th Congress, the House offered a third bill (H.R. 3) also aimed at eliminating abortion funding.<sup>206</sup> Among other things, H.R. 3 made the Hyde Amendment<sup>207</sup> permanent by prohibiting the use of federal funds to cover abortion.<sup>208</sup> It further precluded tax benefits for any health care plan that covered abortion.<sup>209</sup>

H.R. 3 made it clear that abortions could be funded only directly or through coverage “paid for entirely using only funds not authorized or appropriated by Federal law and such coverage shall not be purchased using matching funds required for a federally subsidized program including a State’s or locality’s contribution of Medicaid matching funds.”<sup>210</sup>

The practical consequences of restricting or eliminating abortion coverage for poor women may not directly manifest at the level of abortions foregone.<sup>211</sup> The evidence is mixed, but the bulk of it suggests that most poor women who want abortions locate the funds, even if with significant difficulty, to pay for the procedure.<sup>212</sup> There remain, however, significant psychological and health costs to women who increase their debt, convince friends or relatives to lend them money, or even use money meant for food and rent to pay for an abortion.<sup>213</sup> Moreover, in these situations, women are likely to delay their procedures, which increases health risks.<sup>214</sup> The search for a provider may be discomfoting, and poor

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*tional Abortion Funding Restriction*, JURISTS, July 21, 2011, <http://jurist.org/paperchase/2011/07/house-committee-votes-for-international-abortion-funding-restriction.php>. In July 2011, the House Committee on Foreign Affairs voted to ban U.S. funding to any international organization carrying out abortions. The provision (known as the “Mexico City policy”) was part of the Foreign Relations Appropriations Act. H.R. 2583, 112th Cong. § 922 (2011).

206. H.R. 3, 112th Cong. (2011). The bill passed in the House in a 251–176 vote on May 4, 2011. *H.R. 3: No Taxpayer Funding for Abortion Act*, GOVTRACK, [www.govtrack.us/congress/bill.xpd?bill=h112-3](http://www.govtrack.us/congress/bill.xpd?bill=h112-3) (last visited Oct. 6, 2011). All 235 Republicans who voted supported the bill. Sixteen Democrats voted in favor of the bill, and 175 were opposed. *Roll Call 292 on H.R. 3*, GOP.GOV, <http://www.gop.gov/votes/112/1/292> (last visited Oct. 6, 2011).

207. See *supra* note 103 and accompanying text (discussing the Hyde Amendment).

208. Exceptions are made in cases of rape, incest, and risk to the life of the pregnant woman. H.R. 3, 112th Cong. § 308 (2011).

209. *Id.* §§ 201–03. The bill remains on the Senate Legislative Calendar for consideration. See *Bill Summary & Status*, THE LIBRARY OF CONGRESS, THOMAS, <http://thomas.loc.gov/cgi-bin/bdquery/z?d112:h.r.3>: (last visited Oct. 6, 2011).

210. H.R. 3, 112th Cong. § 304 (2011).

211. Harold Pollack, *How Much Harder Will It Be for Women to Get Abortions?*, THE NEW REPUBLIC, Dec. 23, 2009, <http://www.tnr.com/blog/the-treatment/how-much-harder-will-it-be-wo-men-get-abortions>.

212. In 2009, the cost was between \$400 and \$500. *Id.*

213. *Id.*; see also Gretchen E. Ely & Catherine N. Dulmus, *Abortion Policy and Vulnerable Women in the United States: A Call for Social Work Policy Practice*, 20 J. HUM. BEHAV. SOC. ENV’T 658, 665 (2010) (noting the burdens on poor women who must obtain money for procedures needed for reasons of physical or emotional health when public funding is not available).

214. Dehlendorf & Weitz, *supra* note 18, at 417.

women are often forced to rely on a “frayed” “patchwork of safety-net abortion providers.”<sup>215</sup>

In addition, since passage of the Affordable Care Act, about a dozen states have moved to implement state exchanges that preclude payment for abortion.<sup>216</sup> The exchanges, created by the Act as a venue for purchasing health coverage, are scheduled to become effective in 2014.<sup>217</sup> The exchanges provide a venue for purchasing health coverage for low-income people with incomes above the level of Medicaid eligibility, as well as for some higher-income people.<sup>218</sup> In effect, the state bans on funding for abortion extend the prohibition on the use of federal funds to nongovernmental insurance plans that will offer coverage through the exchanges in the states. It is also likely that insurance coverage for abortion will not be readily available through the larger market.<sup>219</sup> As a result, the majority of women seeking to terminate a pregnancy will be forced to pay for the procedure with personal funds.<sup>220</sup> Once again, the consequences of abortion politics are disproportionately harsh for poor women.

Precluding abortion funding for poor women might be marginally less disturbing were it not simultaneously accompanied by legislative proposals to limit funding for family-planning services. The Affordable Care Act expands Medicaid and offers health coverage through state exchanges to those currently without coverage. The agenda in the House, aimed at limiting or precluding public funding for contraception, magnifies the consequences of failing to provide low-income women coverage for abortion.<sup>221</sup>

### *C. Efforts to Ban the Use of Federal Funds for Family Planning*

Congressional efforts to defund family-planning services have paralleled efforts to limit abortion funding. Republican lawmakers in the

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215. Pollack, *supra* note 211; *see also supra* notes 38–45 and accompanying text.

216. Susan A. Cohen, *Insurance Coverage of Abortion: The Battle to Date and the Battle to Come*, 13 GUTTMACHER POL'Y REV. 2 (2010); Sabrina Tavernise, *Virginia Lawmakers Limit Insurers' Abortion Coverage*, N.Y. TIMES, Apr. 7, 2011, <http://www.nytimes.com/2011/04/07/health/policy/07abortion.html> (reporting that by April of 2011, eight states had prohibited abortion coverage through state exchanges); NAT'L CONFERENCE OF STATE LEGISLATURES, HEALTH REFORM AND ABORTION COVERAGE IN THE INSURANCE EXCHANGES (July 2011), <http://www.ncsl.org/?TabId=21099>. Exceptions exist for cases of rape, incest, or a threat to the life of the pregnant woman.

217. NAT'L CONFERENCE OF STATE LEGISLATURES, *supra* note 216.

218. Pollack, *supra* note 211.

219. Cohen, *supra* note 216.

220. Exceptions exist for certain conditions, including rape, incest, or a threat to the life of the pregnant woman. *Id.*

221. *See supra* notes 211–14 and accompanying text.

112th Congress targeted family-planning services generally and Planned Parenthood clinics in particular.<sup>222</sup> In early February 2011, as part of a budget-cutting agenda, the House passed H.R. 1, which cut all funding to Title X and specifically prohibited the use of any federal funds for Planned Parenthood.<sup>223</sup> The defunding of Planned Parenthood was included as an amendment proposed by Senator Mike Pence (R.-Ind).<sup>224</sup> Congress eventually passed compromise legislation (H.R. 1473) that did not include the Pence Amendment and that continued funding for Title X, albeit at a reduced level.<sup>225</sup> Nonetheless, the 2011 defunding efforts are a powerful indicator of social responses to funding reproductive health care for poor women.

Had Congress passed the budgetary cuts aimed at Title X and Planned Parenthood, the consequences for poor women would have been dismal.<sup>226</sup> Title X clinics, many of which are run by Planned Parenthood, provide low-income women with family-planning services and screening for a variety of diseases, including HIV and other sexually transmitted diseases, and breast and cervical cancers.<sup>227</sup> About 25% of poor women who receive contraceptive services obtain them through Title X-funded clinics.<sup>228</sup> More generally, about 50% of low-income women in the United States who do receive contraceptive care receive that care through

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222. Erick Eckholm, *Planned Parenthood Financing is Caught in Budget Feud*, N.Y. TIMES, Feb. 17, 2011, <http://www.nytimes.com/2011/02/18/us/politics/18parenthood.html>. Planned Parenthood receives about one-third of its funding through Title X. Linda Feldmann, *Planned Parenthood: Deal-Breaker or Trump Card in Government-Shutdown Talks?*, CHRISTIAN SCI. MONITOR, Apr. 8, 2011, <http://www.csmonitor.com/USA/Politics/2011/0408/Planned-Parenthood-deal-breaker-or-trump-p-card-in-government-shutdown-talks>.

223. H.R. 1, 112th Cong. (2011). See also Susan A. Cohen, *The Numbers Tell the Story: The Reach and Impact of Title X*, 14 GUTTMACHER POL'Y REV. 20 (2011); Aimee Miles, *A Guide to GOP Proposals on Family Planning Funds*, KAISER HEALTH NEWS (Mar. 9, 2011), <http://www.kaiserhealthnews.org/Stories/2011/February/18/planned-parenthood-title-10.aspx>. The “Pence Amendment” to H.R. 1 (H. Amdt. 95) was approved by the House (240–185) on February 18, 2011. *Bill Summary & Status, 112th Congress (2011–2012), H.AMDT 95*, THE LIBRARY OF CONGRESS, THOMAS, <http://thomas.loc.gov/cgi-bin/bdquery/D?d112:85.:temp/~bdYcab:> (last visited Oct. 15, 2011). Congress later considered the prohibition as an “enrollment correction” (H. Con. Res. 36) to the subsequent compromise legislation, H.R. 1473. The resolution passed in the House (241–185), but it was defeated in the Senate (42–58). *Bill Summary & Status, 112th Congress (2011–2012), H.CON.RES.36*, THE LIBRARY OF CONGRESS, THOMAS, <http://thomas.loc.gov/cgi-bin/bdquery/z?d112:HC00036:@@L&summ2=m&> (last visited Oct. 15, 2011). In this Article, the Amendment and the proposal will be jointly referred to as the “Pence Amendment.”

224. Miles, *supra* note 223.

225. Press Release, Committee on Appropriations—Democrats, U.S. House of Representatives, Summary of H.R. 1473; FY2011 Appropriations (Apr. 12, 2011), [http://democrats.appropriations.house.gov/index.php?option=com\\_content&task=view&id=767&Itemid=28](http://democrats.appropriations.house.gov/index.php?option=com_content&task=view&id=767&Itemid=28).

226. Cohen, *supra* note 223; see also Annas et al., *supra* note 195.

227. Annas et al., *supra* note 195, at 1590.

228. Cohen, *supra* note 223, at 20.

publicly funded family-planning clinics.<sup>229</sup> For many of the women using these services, such clinics provide their only source of health care.<sup>230</sup> Moreover, the consequences of defunding family-planning clinics would be especially dire for poor women in light of existing strictures on federal funding for abortion. Deprived of funding for contraceptive services, poor women would be more likely to face unintended pregnancies.

Supporters of H.R. 1 and the Pence Amendment variously touted the measures by arguing that they demonstrated fiscal restraint<sup>231</sup> and that the measures represented a stance against abortion.<sup>232</sup> The two matters, though conflated in Congress, are not consistent.<sup>233</sup> Even more, if suc-

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229. Rachel Benson Gold, *The Role of Family Planning Centers as Gateways to Health Coverage and Care*, 14 GUTTMACHER POL'Y REV. 2 (2011).

230. *Id.* Gold reports one study that showed that Planned Parenthood centers in Los Angeles provide the only source of health care to almost 30% of adult clients and to almost 20% of adolescent clients. *Id.* (citing S. Sugeman et al., *Family Planning Clinic Clients: Their Usual Health Care Providers, Insurance Status, and Implications for Managed Care*, 27 J. ADOLESCENT HEALTH 25 (2000)).

The value of the care provided by Title X clinics is highlighted in a 2011 report issued by the Institute of Medicine (IOM) several months after Congress considered the Pence Amendment. COMM. ON PREVENTIVE SERVS. FOR WOMEN, CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 21 (2011); see also Robert Pear, *Panel Recommends Coverage for Contraception*, N.Y. TIMES, July 19, 2011, <http://www.nytimes.com/2011/07/20/health/policy/20health.html>. The report recommended that under the Affordable Care Act insurers should be required to offer contraceptive care to all women at no cost. COMM. ON PREVENTIVE SERVS. FOR WOMEN, *supra*, at 22. An official summary of the report's recommendations regarding preventive care for women pursuant to the Affordable Care Act described reducing unintended pregnancies as a positive goal and asserted that the goal can be achieved through the use of contraception and through contraceptive counseling. *Id.* at 23. In consequence, the IOM Committee suggested that pursuant to the Affordable Care Act, all women with reproductive capacity be offered "the full range of Food and Drug Administration-approved contraceptive methods." *Id.* The Secretary of Health and Human Services responded almost immediately by issuing standards pursuant to the Affordable Care Act that would require insurers to cover all FDA-approved contraception without co-payments. N. C. Aizenman, *New U.S. Rules Require Insurance Coverage for Contraception*, WASH. POST, Aug. 1, 2011, [http://www.washingtonpost.com/national/health-science/new-us-rules-require-insurance-coverage-for-contraception/2011/08/01/gIQAwdTRoI\\_story.html](http://www.washingtonpost.com/national/health-science/new-us-rules-require-insurance-coverage-for-contraception/2011/08/01/gIQAwdTRoI_story.html). The proposed new standards provide an exemption for certain religious organizations. *Id.* Yet, the rules have no immediate consequence for women without health insurance. Robert Pear, *Insurance Coverage for Contraception Is Required*, N.Y. TIMES, Aug. 1, 2011, <http://www.nytimes.com/2011/08/02/health/policy/02health.html>.

231. See, e.g., Grover Norquist & Marjorie Dannenfelser, *Economic and Social Conservatives Agree: Cut Planned Parenthood*, NAT'L REV. ONLINE (Mar. 7, 2011), <http://www.nationalreview.com/corner/261444/economic-and-social-conservatives-agree-cut-planned-parenthood-grover-norquist>.

232. Scott Forsyth, *Commentary: House: Don't Single Out Planned Parenthood*, ROCHESTER DAILY REC., Mar. 9, 2011, [http://findarticles.com/p/articles/mi\\_qn4180/is\\_20110309/ai\\_n57082786/](http://findarticles.com/p/articles/mi_qn4180/is_20110309/ai_n57082786/); Miles, *supra* note 223 (noting that Title X recipients are permitted to provide abortion services with segregated funds). Planned Parenthood clinics segregate funding and administrative activities relating to abortion from activities related to contraception and other health care services. Feldmann, *supra* note 222.

233. See Amanda Marcotte, *Why Fiscal Conservatives Should Embrace Planned Parenthood*, SLATE (Mar. 28, 2011), [http://www.slate.com/articles/double\\_x/doublex/2011/03/why\\_fiscal\\_conser](http://www.slate.com/articles/double_x/doublex/2011/03/why_fiscal_conser)



cessful, the measures would have served neither end.<sup>234</sup> They would have been costly, and they would have increased the rate of abortion.<sup>235</sup>

Eliminating or significantly cutting public funding for reproductive health care to low-income women, including contraceptive care, would likely increase the birth rate.<sup>236</sup> In 2009, a Guttmacher Institute report estimated that eliminating clinics funded through Title X would have led to 860,000 additional unintended pregnancies and 810,000 additional abortions per year for poor women.<sup>237</sup> In 2008, the cost of a birth to Medicaid, including prenatal, delivery, and postpartum care for the pregnant woman, as well as care for the baby for one year after the child’s birth, was \$12,613.<sup>238</sup> Contraceptive care in the same year cost \$257 for each Medicaid-covered user.<sup>239</sup>

Beyond their budgetary consequences, the failed measures would almost certainly have resulted in an increased number of abortions among the women they targeted.<sup>240</sup> Unequal access to family-planning services makes it difficult for poor women to obtain contraception and to use it over time.<sup>241</sup> H.R. 1 and the Pence Amendment would have significantly worsened that situation. Poor women, without easy access to contraceptive care, are at risk for unintended pregnancies. They are more likely than other women to have unplanned children. But at least some of these women will decide to terminate their pregnancies despite the absence of Medicaid funding for abortion.<sup>242</sup>

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vatives\_should\_embrace\_planned\_parenthood.html; see also Nancy Gibbs, *The Baby and the Bathwater*, TIME MAG., Mar. 14, 2011, <http://www.time.com/time/magazine/article/0,9171,2056716,00.html?artId=2056716?contType=article?chn=us>.

234. See Marcotte, *supra* note 233.

235. Though Planned Parenthood was targeted as an abortion provider, a very small part of the organization’s budget, in fact, has been used to cover abortion costs. Annas et al., *supra* note 195, at 1591 (reporting that about 3% of Planned Parenthood’s budget covers abortions). In addition, none of the abortions performed by Planned Parenthood are paid for with federal funds. *Id.*

236. Title X is the source of about 12% of public funding, while the largest source is Medicaid (71%). Amy Norton, *U.S. Abortion Rate Down, But Up Among Poor Women*, REUTERS (May 23, 2011), <http://www.reuters.com/article/2011/05/23/us-abortion-rate-idUSTRE74M6J420110523>.

237. Annas et al., *supra* note 195, at 1591 (citing RACHEL BENSON GOLD ET AL., NEXT STEPS FOR AMERICA’S FAMILY PLANNING PROGRAM, GUTTMACHER INST. (2009), available at <http://www.guttmacher.org/pubs/NextSteps.pdf>).

238. Kelly Cleland et al., *Family Planning as a Cost-Saving Preventive Health Service*, 364 NEW ENG. J. MED. 37, 39 (2011).

239. *Id.*

240. *Id.*; see also Annas et al., *supra* note 195, at 1591 (citing GOLD ET AL., *supra* note 237).

241. Michelle Chen, *Demographics of Abortion: Race, Poverty and Choice*, HUFFINGTON POST (May 7, 2010), [http://www.huffingtonpost.com/michelle-chen/demographics-of-abortion\\_b\\_567915.html](http://www.huffingtonpost.com/michelle-chen/demographics-of-abortion_b_567915.html).

242. *Id.* (noting that “the profile of the abortion patient is disproportionately poor, as well as disproportionately Black or Latina”); Scott Johnson, *Health Care Disparities at Issue in Abortion Rates Among Black Americans*, SAN JOSE MERCURY NEWS, July 11, 2011 (noting that the disproportionate rate of abortion among African-American women is due to “a widespread pattern of health

As commentators have noted, debate over the Amendment reflected both abortion politics and Congress's attempt to trim the federal budget.<sup>243</sup> But the ramifications of both matters extend more broadly. The Pence Amendment reflected the complicated shifts in strategy that mark the American debate about abortion.<sup>244</sup> The implications of abortion politics have often been far-reaching. Correlatively, the American debate (or more accurately, debates) about abortion has frequently offered the public a rhetorical stage upon which people have defined and categorized themselves and others with reference to shifting political tendencies, religious affiliations, and sociocultural sentiments. Often the politics of abortion agendas only connect indirectly to abortion in the most specific sense.<sup>245</sup> As Congress debated H.R. 1 and the Pence Amendment, it therein also debated class, gender, and inequalities in the provision of the nation's system of health care coverage. As a spokesperson for Black Women for Reproductive Justice, responding to an anti-abortion billboard campaign across many cities during the summer of 2011, declared: "They want to make this about abortion, but this is about health disparities."<sup>246</sup>

More accurately, "this" *is* about abortion. And it is *also* about health care disparities. In the United States, abortion politics has long been a compelling context within which to present other agendas.<sup>247</sup> Insofar as health care disparities and the ideology of class that they reflect are now at the center of the nation's concerns, it is unsurprising that abortion politics voices these interests.

#### *D. States' Limitations on Abortion and Family-Planning Services*

Recently, many state legislatures have entertained or passed bills that limit the right to abortion or trim state funding for abortions and family planning. The first subsection reviews new state laws that limit women's right to abortion and notes the particular impact of those laws

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disparities in low-income and minority communities that prevents women from obtaining effective contraception").

243. Feldmann, *supra* note 222; Ryan Grim, *Government Shutdown Threatened by Republicans Over Planned Parenthood*, HUFFINGTON POST (Apr. 7, 2011), [http://www.huffingtonpost.com/2011/04/07/government-shutdown-planned-parenthood\\_n\\_846463.html](http://www.huffingtonpost.com/2011/04/07/government-shutdown-planned-parenthood_n_846463.html).

244. Dolgin, *supra* note 20, at 114–28 (reviewing shifts in debate about abortion from the nineteenth century to the late-twentieth century in the United States); *see also* Liz Halloran, *Abortion Foes Target Family Planning Program*, NAT'L PUB. RADIO (Mar. 21, 2011), <http://www.npr.org/2011/03/22/134662664/abortion-foes-target-family-planning-program>.

245. Cohen, *supra* note 223, at 20.

246. Johnson, *supra* note 242. The anti-abortion billboards were paid for and distributed by a pro-life group, Issues4Life. *Id.*

247. *See supra* Part II.

on poor women. The second subsection reviews states’ attempts to limit funding for abortion or family-planning services.

### 1. State Efforts to Limit Abortion

In the first few months of 2011, nineteen states cumulatively enacted thirty laws that curtailed women’s right to abortion.<sup>248</sup> In comparison, states passed twenty-three similar bills in 2010.<sup>249</sup> These laws have imposed waiting periods on women seeking abortions, required women to look at ultrasound images of the fetus, and prohibited abortions after twenty weeks of gestation.<sup>250</sup> The same anti-abortion politics that energized Congress to limit funding for abortions and for family-planning services is also reflected at the state level.

In the first half of 2011, five states enacted abortion bans after twenty weeks of gestation—a point at which the fetus is not viable.<sup>251</sup> Ten other state legislatures entertained similar bills. These laws<sup>252</sup> were justified with the presumption—denied by established medical groups—that the fetus feels pain at twenty weeks.<sup>253</sup>

A bill passed by Ohio’s legislative House in June 2011 would ban abortions after detection of a fetal heartbeat, which usually happens between weeks six and ten.<sup>254</sup> Fourteen states have considered bills that restrict abortions performed with the use of medication rather than surgical procedures. Six of those fourteen bills have been enacted.<sup>255</sup> In addition, eight states have passed laws that restrict coverage for abortion

248. GUTTMACHER INST., STATES ENACT RECORD NUMBER OF ABORTION RESTRICTIONS IN FIRST HALF OF 2011 (2011), <http://www.guttmacher.org/media/inthenews/2011/07/13/index.html>.

249. *Id.*

250. Erik Eckholm, *Several States Forbid Abortion After 20 Weeks*, N.Y. TIMES, June 26, 2011, <http://www.nytimes.com/2011/06/27/us/27abortion.html>.

251. GUTTMACHER INST., LAWS AFFECTING REPRODUCTIVE HEALTH AND RIGHTS: STATE TRENDS AT MIDYEAR (2011), <http://www.guttmacher.org/statecenter/updates/2011/statetrends22011.html> (reporting enactment of such laws in Alabama, Idaho, Indiana, Kansas, and Oklahoma). *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), bars rules that prohibit abortions before viability if the laws place an “undue burden” on the pregnant woman. Nebraska passed a similar law in 2010. Eckholm, *supra* note 250.

252. These laws are open to constitutional challenge. *Casey*, 505 U.S. at 877 (precluding abortion bans before viability that impose “undue burden” on pregnant woman seeking abortion).

253. Eckholm, *supra* note 250. The laws prohibiting abortion after twenty weeks do not provide exceptions for rape or incest, for medical threats to the mother (short of a threat of death or “serious physical impairment of a major bodily function”), or for cases in which it is discovered that a fetus is devastatingly impaired. *Id.* Groups opposed to abortion hope that Republican candidates for the presidency will sign a pledge in support of legislative efforts to ban abortions after some specific gestational point. *Id.*

254. Maureen Cosgrove, *Ohio Governor Signs Bill Banning Abortions After 20 Weeks*, JURIST (July 20, 2011), <http://jurist.org/paperchase/2011/07/ohio-governor-signs-bill-banning-abortions-after-20-weeks.php>.

255. GUTTMACHER INST., *supra* note 251.

through state exchanges that will be implemented pursuant to the Affordable Care Act, as well as coverage through private health insurance plans.<sup>256</sup> Six other states restrict coverage through state health exchanges but not through private insurance plans.<sup>257</sup>

Although these laws seem to be aimed equally at all pregnant women seeking abortions, their impact is again felt most harshly by poor women. First, poor women are likely to find it harder than middle- or upper-class women to travel to other states or other nations for abortions.<sup>258</sup> Second, poor women now have abortions more often.<sup>259</sup> Between 2000 and 2008, the rate of abortions among poor women increased (from 27% to 42%).<sup>260</sup>

Additionally, even before enactment of these laws, poor women—long denied adequate access to abortion—were more likely to carry unintended pregnancies to term.<sup>261</sup> In some part, these disproportionate numbers are consequences of cuts in funding for family-planning services that restrict poor women's access to contraception.<sup>262</sup>

## 2. State Efforts to Defund Family-Planning Services

Several states have attempted to limit state funding for Planned Parenthood specifically.<sup>263</sup> Following Congress's lead, these state governments justified singling out Planned Parenthood by noting that in addition to providing family-planning services and other forms of routine reproductive care, the organization performs abortions.<sup>264</sup> North Carolina's response is illustrative.

In the spring of 2011, North Carolina passed a budget precluding public funding for Planned Parenthood clinics.<sup>265</sup> Janet Colm, the President of Planned Parenthood of Central North Carolina, noted that the bill represented the first time that the state legislature had singled out one health care provider and "banned [it] from applying for competitive

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256. *Id.*

257. *Id.*

258. Dehlendorf & Weitz, *supra* note 18, at 416.

259. *Id.* at 415.

260. *Id.*

261. *Id.* at 417 (citing L. B. Finer & S. K. Henshaw, *Disparities in Rate of Unintended Pregnancy in the United States, 1994 and 2001*, 38 PERSP. ON SEXUAL & REPROD. HEALTH 90 (2006)).

262. See *supra* notes 222–30 and accompanying text.

263. *Defunding Planned Parenthood: State by State Scoreboard*, SUSAN B. ANTHONY LIST, <http://www.sba-list.org/PPScoreboard> (last visited Oct. 25, 2011).

264. See *supra* note 235.

265. Zach Zagger, *Planned Parenthood Seeks to Block North Carolina from Defunding It*, JURIST, July 8, 2011, <http://jurist.org/paperchase/2011/07/planned-parenthood-seeks-to-block-north-carolina-from-defunding-it.php>. The law was passed over the veto of North Carolina Governor Beverly Perdue. *Id.*

grants from the state.”<sup>266</sup> About 70% of people receiving reproductive health care from Planned Parenthood of North Carolina do not have health care coverage.<sup>267</sup> One North Carolina legislator explained the legislation by declaring that the state’s legislature has the right to decide “who is going to provide services with taxpayer dollars.”<sup>268</sup>

North Carolina<sup>269</sup> justified targeting Planned Parenthood for defunding by referencing its abortion services.<sup>270</sup> In fact, Planned Parenthood’s family-planning services reach many women beyond those who seek abortion services.<sup>271</sup> The majority of women receiving care at Planned Parenthood clinics get birth control from the clinics.<sup>272</sup>

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266. *Id.*

267. *Planned Parenthood Sues Over Cuts in N.C. Budget*, WRAL (July 7, 2011), <http://www.wral.com/news/state/nccapitol/story/9830150/>.

268. *Id.* (quoting Rep. Nelson Dollar, R-Wake County).

269. Variations occurred in other states. In Indiana, for instance, a law banning the distribution of state funds to Planned Parenthood became effective in May 2011. The Indiana law makes it impermissible for the state to enter into an agreement with or provide funds to “any entity that performs abortions or maintains or operates a facility where abortions are performed.” H.R. 1210, 117th Gen. Assembly, 1st Sess. (Ind. 2011), available at <http://www.in.gov/legislative/bills/2011/HE/HE1210.1.html>. The federal government contended in a letter sent by Donald Berwick, administrator of the Centers for Medicare and Medicaid Services, that states cannot restrict providers for Medicaid beneficiaries for reasons unrelated to a provider’s limitations. Zach Zaggar, *Indiana to Appeal Ruling on Planned Parenthood Funding*, JURIST (June 29, 2011) [hereinafter Zaggar, *Indiana to Appeal Ruling*], [www.jurist.org/paperchase/2011/06/Indiana-to-appeal-ruling-on-planned-parenthood-funding.php](http://www.jurist.org/paperchase/2011/06/Indiana-to-appeal-ruling-on-planned-parenthood-funding.php); see also Robert Pear, *U.S. Objects to New Law on Clinics in Indiana*, N.Y. TIMES, May 22, 2011, <http://www.nytimes.com/2011/05/23/us/politics/23abort.html>. Such an alteration in a state Medicaid program is open to federal review. The Obama administration responded to the Indiana law as an unacceptable restriction on Medicaid recipients’ choice of provider. *Id.* The Indiana law bans the distribution of Medicaid funds to cover even general reproductive health services (such as breast exams and Pap tests) at Planned Parenthood clinics in the state. WRAL, *supra* note 267. Berwick’s letter also explained that the statute violated federal law by limiting the right of people receiving care through Medicaid to select their health care providers. Editorial, *When States Punish Women*, N.Y. TIMES, June 2, 2011, <http://www.nytimes.com/2011/06/03/opinion/03fri1.html>. Since then, the Indiana law has been enjoined by the United States District Court for the Southern District of Indiana. Zaggar, *Indiana to Appeal Ruling*, *supra*.

In May 2011, Minnesota’s governor vetoed a bill that restricted the use of state funds to pay for abortions. Zach Zaggar, *Minnesota Governor Vetoes Bills Restricting Abortion Rights*, JURIST (May 26, 2011), <http://jurist.org/paperchase/2011/05/minnesota-governor-vetoes-bills-restricting-abortion-rights.php>. The governor also vetoed a twin bill that banned abortions completely after twenty weeks of gestation. *Id.*; see also Eric Roper, *Dayton Vetoes Abortion Bills*, STAR TRIB., May 25, 2011, <http://www.startribune.com/politics/statelocal/122612454.html>.

270. Pear, *supra* note 269.

271. A very small share (about 3%) of Planned Parenthood clinics’ budgets go toward abortions. Annas et al., *supra* note 195, at 1591.

272. Pear, *supra* note 269. Pear reports that in 2010, Planned Parenthood of Indiana provided care to 85,000 patients. Of this group, 5,580 had abortions, but the majority of patients received contraception. Over 20,000 had pregnancy tests, 26,500 had Pap tests, and about 33,000 were tested for sexually transmitted diseases. *Id.*

Efforts to defund Planned Parenthood reflect class anxiety, as well as opposition to abortion.<sup>273</sup> To many, the reproductive health needs of poor women signal the presumed irresponsibility of the women and of their class.<sup>274</sup> For instance, many of the people who posted comments in response to a news story about North Carolina's ban on state funding for Planned Parenthood clinics voiced these sentiments.<sup>275</sup> One broad group of comments bemoaned the irresponsibility of women who rely on Planned Parenthood services funded by the state. Another said it was unfair that the public must pay for such services through taxes. A few focused equally on both matters. One commenter, concentrating on poor women's presumptive irresponsibility, explained:

God forbid anyone try to teach personal responsibility instead of "oh well, we don't want it . . . someone else take care of it, or pay for me to get rid of it." If you don't want babies, don't have sex. If you can't abstain, use birth control or get your tubes tied. If you can't afford either, you can't afford to have sex.<sup>276</sup>

Another commenter, responding to the proposition that sex is a biological imperative, exclaimed: "What happened to personal responsibility in this country. If you have consensual sex and get pregnant the results are your responsibility. Calling sex a 'biological imperative' is a way for liberals and Democrats to remove responsibility for getting pregnant from the woman and man who impregnated her."<sup>277</sup>

Other commenters were concerned with financial issues. "What's Planned Parenthood for again?" asked one, and then answered the query: "Another wasteful program paid for by us?"<sup>278</sup> Another explained the "Republican plan" for unplanned children carried to term, should abortion become illegal:

Umm it's called parenting. How many abortions do you believe is okay for EVERY American to pay for out of OUR money? How

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273. Defunding Planned Parenthood limits reproductive health care for thousands and thousands of poor women, many of whom have no other source of coverage for health care. *Id.* Pear reports that 9,300 of the 85,000 people who received care from Planned Parenthood of Indiana in 2010 were covered by Medicaid. *Id.*; see also WRAL, *supra* note 267. Nationwide, Planned Parenthood clinics serve over 1.8 million low-income people each year. Collins, *supra* note 204.

274. See *infra* Part V.

275. At the time of publication, there were 337 postings responding to WRAL's story *Planned Parenthood Sues Over Cuts in N.C. Budget*. WRAL, *supra* note 267.

276. myjudas, Comment to *Planned Parenthood Sues Over Cuts in N.C. Budget*, WRAL (July 7, 2011, 4:40 PM), <http://www.wral.com/news/state/nccapitol/story/9830150/>.

277. DontLikeTheSocialistObama, Comment to *Planned Parenthood Sues Over Cuts in N.C. Budget*, WRAL (July 7, 2011, 5:10 PM), <http://www.wral.com/news/state/nccapitol/story/9830150/>.

278. Haggis basher, Comment to *Planned Parenthood Sues Over Cuts in N.C. Budget*, WRAL (July 8, 2011, 12:40 PM), <http://www.wral.com/news/state/nccapitol/story/9830150/>.

about 3 per household. I mean abortions for each woman? Let’s allow the Doctors to use screw drivers like that guy up East who performed 1000s of them, where’d he get the money do you suppose?<sup>279</sup>

A number of postings stressed the limits of public responsibility and expressed anger at the unfairness of charging others for the consequences of poor women’s irresponsibility. One poster in this group declared:

As heartless as it sounds, it’s not the public’s responsibility to fund planned parenthood. I mean goodness, the people USING planned parenthood are more than likely getting all their medical bills paid by the taxpayers as well. Sounds stereotypical, but call it like it is, people. WE all know the truth. And I’m tired of funding entitlements. I work hard for my family, and that’s all I’m responsible for. Not my neighbor, not my friends, not anyone else. I can care about them, but I’m not responsible to pay their bills or take care of them. Period.<sup>280</sup>

#### V. REPRODUCTION, THE AFFORDABLE CARE ACT, AND THE POOR WOMAN AS “OTHER”

Responses throughout the nation from those who opposed national health care reform more generally reflected similar sentiments. For instance, many opponents—legal scholars,<sup>281</sup> politicians,<sup>282</sup> and others<sup>283</sup>—saw choice and liberty as the targets of any health care reform that would significantly expand access to health care. Other critics contended that the Affordable Care Act would result in higher taxes and increased government control over people’s private lives.<sup>284</sup>

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279. Gunny462, Comment to *Planned Parenthood Sues Over Cuts in N.C. Budget*, WRAL (July 7, 2011, 4:32 PM), <http://www.wral.com/news/state/nccapitol/story/9830150/>.

280. Lovethesouth1, Comment to *Planned Parenthood Sues Over Cuts in N.C. Budget*, WRAL (July 7, 2011, 3:44 PM), <http://www.wral.com/news/state/nccapitol/story/9830150/>.

281. See, e.g., Richard A. Epstein, *Bleak Prospects: How Health Care Reform Has Failed in the United States*, 15 TEX. REV. L. & POL. 1, 5–6 (2010) (noting that as Obamacare leads to “an unfortunate mad scramble of political intrigue among health care providers” and others seeking the best reimbursement rates, “the persistent decline in both liberty and prosperity in the United States will continue apace”).

282. See, e.g., Andy Birkey, *Bachmann: “Obama Wants to Annihilate Us!”*, MINN. INDEP., Feb. 5, 2010, <http://minnesotaindependent.com/55035/bachmann-obama-wants-to-annihilate-us> (quoting Representative Michele Bachmann fund-raising letter that described health care reform and other programs of the Obama administration as a “danger to our freedoms”).

283. See, e.g., Patrick McIlheran, *Because What You Want Doesn’t Matter*, J. SENTINEL, Feb. 25, 2010 (contending that “Obamacare” would deprive people of choice by affecting a “government takeover of insurance”).

284. See, e.g., James Capretta, *Dr. Obama’s Prescription*, NAT’L REV. ONLINE (Sept. 1, 2008), [http://www.eppc.org/publications/pubID.3522/pub\\_detail.asp](http://www.eppc.org/publications/pubID.3522/pub_detail.asp); James R. Edwards, Jr., *Obama’s*

Yet, in the weeks just before passage of the Affordable Care Act, the politics of abortion seemed to displace all of these concerns about the bill.<sup>285</sup> The very passage of the bill hinged on one issue: federal funding for abortion. And once again, the debate about abortion offered a stage on which to entertain many controversial issues. In effect, the politics of health care reform were conflated with, and entertained under the guise of, the politics of abortion.

This conflation harmed poor women more than other women because the focus of the debate was not the procedure itself, but rather its funding. Through the politics of abortion, poor women in need of reproductive services became symbols of the perennial “American Other.”<sup>286</sup> Increasingly, these women were portrayed as undeserving and irresponsible.<sup>287</sup> Characterized as unworthy, women who depended on state assistance for reproductive care were increasingly at risk of losing access to health care benefits essential to their well-being and to that of their children.

Section A of this Part reviews several parameters of an American class ideology<sup>288</sup> that fuels a national need to marginalize certain people (often identified through gender, race, or ethnicity) as social or economic “Others.”<sup>289</sup> Section B illustrates the consequences of that ideology for poor women of childbearing age and explores the ramifications of that stigmatization while congressional debate about health care reform raged on in March 2010. In effect, poor women of childbearing age were marked as “Others” in the health care debate. Their health care needs were considered less important than those of other groups. Marking poor women as outsiders unable to enjoy the full benefits promised by health

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*Health Reform Needs Medicine*, HUMAN EVENTS (June 18, 2008), <http://www.humanevents.com/article.php?id=27077>.

285. See *supra* Part IV.A.

286. Within the American context, the “Other” has often been identified through reference to race, ethnicity, and gender. See Etienne Balibar, *Difference, Otherness, Exclusion*, 11 PARALLAX 19 (2005) (describing reification of “Other” who becomes threatening in comparison to the “Self”). This Article considers another set of external marks of the “Other” within the setting of the American class system. Among these marks are indications of comparatively good or ill-health. This Part considers the role played in stigmatizing poor women as “Others” by efforts to limit funding for reproductive care. See Marcel Mauss, *A Category of the Human Mind: The Notion of Person; The Notion of Self*, in THE CATEGORY OF THE PERSON: ANTHROPOLOGY, PHILOSOPHY, HISTORY 1, 3 (Michael Carrithers et al. eds., 1985); see also Cleland et al., *supra* note 238.

287. See *supra* note 286 and accompanying text (describing meaning of the term “Other” as used here).

288. See *supra* note 9 (defining “ideology” as used in this Article).

289. Virtually all societies affect, and often value, social rankings. See, e.g., DAVID BERREBY, *US AND THEM: THE SCIENCE OF IDENTITY* (2005) (exploring the social and psychological processes that facilitate social categorizations of people). This section considers some of the specific parameters of socioeconomic ranking in American society.



care reform threatens to widen deep disparities in health care coverage that reform was intended to redress. This exclusion reflects the nation's opaque understanding of, and pervasive anxiety about, socioeconomic status.

#### A. Status and Class Competition

American society has long valued individualism and autonomy. Americans view individuals' socioeconomic status as an offshoot of personal choices.<sup>290</sup> Yet, even as they assess their own and each others' social status, Americans mask the reality of the nation's class system.<sup>291</sup> That is, the social assumptions that underlie class status in the United States are both pervasive and largely opaque.

The consequence is anxiety and confusion. Americans believe, for instance, that one can avoid poverty or even move up in class status through responsibility and hard work. But in reality, social mobility is rare rather than common.<sup>292</sup> On the whole, Americans are more concerned with relative rather than absolute status. They focus on where they stand in comparison to others.<sup>293</sup> American society lacks determinative marks of socioeconomic status. That is to say, Americans have few certain indicia for assessing socioeconomic class.<sup>294</sup> Class tension is furthered by pervasive concern about safeguarding one's own status relative to others.<sup>295</sup>

Since the nation's most recent economic downturn in 2008, Americans' anxiety has been fueled by the increasing difficulty of sustaining class status for everyone but the very rich.<sup>296</sup> Many have lost jobs or have

290. Janny Scott & David Leonhardt, *Class in America: Shadowy Lines That Still Divide*, N.Y. TIMES, May 15, 2005, <http://www.nytimes.com/2005/05/15/national/class/OVERVIEW-FINAL.html?pagewanted=all>.

291. Erika Blacksher, *Health care Disparities: The Salience of Social Class*, 17 CAMBRIDGE Q. HEALTH CARE ETHICS 143, 144 (2008) (noting that class status in the United States is often "suppressed").

292. Scott & Leonhardt, *supra* note 290 (noting that studies reporting class mobility could be challenged in cases in which they relied on personal memories of familial status during childhood or on income figures for short time periods).

293. Erzo F. P. Luttmer, *Neighbors as Negatives: Relative Earning and Well-Being*, 120 Q. J. ECON. 963, 989 (2005), available at <http://www.nber.org/~luttmer/relative.pdf> (finding that self-reported happiness correlates negatively with neighbors' earning higher incomes).

294. See Scott & Leonhardt, *supra* note 290.

295. Luttmer, *supra* note 293, at 989; KAISER FAMILY FOUND., NPR/KAISER FAMILY FOUNDATION/HARVARD SCHOOL OF PUBLIC HEALTH, PUBLIC VIEWS ON SCHIP REAUTHORIZATION: SURVEY HIGHLIGHTS 3 (2007), [www.kff.org/kaiserpolls/pomr101707pkg.cfm](http://www.kff.org/kaiserpolls/pomr101707pkg.cfm).

296. *As Income Gap Balloons, Is It Holding Back Growth?*, NAT'L PUB. RADIO (July 15, 2011), <http://www.npr.org/2011/07/10/137744694/as-income-gap-balloons-is-it-holding-back-growth>. In 2011, the gap between the poor and the rich in the United States was wider than since 1928. *Id.* National Public Radio reported that in the last year, "top CEO salaries were up 23 percent" while the pay of the average worker increased by 0.5%. *Id.*

taken lower paying jobs than those they held before the recession.<sup>297</sup> As a result, anxiety about class status is now far more palpable than before 2008.<sup>298</sup> Other socioeconomic disparities add to the tensions. In 2011, Sarah Bloom Raskin, a Federal Reserve governor, explained that “growing levels of income inequality are associated with increases in crime, profound strains on households, lower savings rates, poorer health outcomes, [and] diminished levels of trust . . . .”<sup>299</sup>

Americans look to a shifting variety of material goods and cultural preferences when assessing their own class status as well as others’, especially those who are presumed to be relatively close to them on the socioeconomic hierarchy. Indicators of class status include tastes in music, sports, or books, clothing, cars, home furnishings, and residential location. Over time, specific markers of socioeconomic status—especially material goods—shift so that signs of high status one year become irrelevant the next. As a result, people become less certain and more anxious about where they stand in the nation’s socioeconomic hierarchy in relation to others.<sup>300</sup>

Thus, Americans perpetually seek additional markers of socioeconomic status—though generally without self-consciousness.<sup>301</sup> They have, for instance, located a complicated but powerful set of indicia of class status in each others’ bodies. Certain fairly visible indicia of good or ill-health provide significant markers of status insofar as people assume, very often correctly, that poor health attends economic hardship and low socioeconomic status.<sup>302</sup> In fact, there is a stunning correlation between relative health status and relative socioeconomic status.<sup>303</sup>

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297. Robert Reich, *The Root of Economic Fragility and Political Anger*, SALON, July 13, 2010, [http://www.salon.com/news/great\\_recession/index.html?story=/news/feature/2010/07/13/reich\\_economic\\_anger](http://www.salon.com/news/great_recession/index.html?story=/news/feature/2010/07/13/reich_economic_anger).

298. See, e.g., William Galston, *America May Never Be the Same*, BROOKINGS, July 19, 2010, [http://www.brookings.edu/opinions/2010/0702\\_america\\_galston.aspx](http://www.brookings.edu/opinions/2010/0702_america_galston.aspx).

299. *As Income Gap Balloons, Is It Holding Back Growth?*, *supra* note 296 (Raskin offered her explanation to Guy Raz, a National Public Radio host, on the program *All Things Considered*).

300. See, e.g., Jennifer Steinhauer, *When the Joneses Wear Jeans*, N.Y. TIMES, May 29, 2005, <http://www.nytimes.com/2005/05/29/national/class/CONSUMPTION-FINAL.html?pagewanted=all> (noting a large percentage of Americans are concerned with owning high-status goods).

301. See *infra* notes 305–10.

302. RICHARD WILKINSON & KATE PICKETT, *THE SPIRIT LEVEL: WHY GREATER EQUALITY MAKES SOCIETIES STRONGER* 163 (2009) (noting some health consequences of living in segregated neighborhoods, including “increased commuting times, . . . increased risk of traffic accidents, worse schools, poor levels of services, exposure to gang violence, pollution, and so on”).

303. Remarkably, the correlation between relative health status and relative socioeconomic status cannot be fully explained by differential access to health care. See MICHAEL MARMOT, *THE STATUS SYNDROME* 38–43 (2004) (describing correlation between social gradient in health and position in British civil service).

Thus, often unconsciously, people seek visible signs of health status as evidence of socioeconomic status. They assess each others’ bodies and faces quickly and without conscious thought, and then rely on their assessments as a measure of relative socioeconomic rank.<sup>304</sup> They do this much as they assess each others’ clothes or homes or automobiles. Among the more telling signs of health and ill-health as marks of socioeconomic status are dental condition, posture, hair, skin, body size (especially the presence or absence of central-body adiposity), and an overall indication of energy or fatigue.<sup>305</sup> Dental condition, for instance, is a cogent marker of socioeconomic status. Dental problems during childhood—one of the “most prevalent unmet health needs” of children<sup>306</sup>—have lifelong consequences.<sup>307</sup> Similarly, obesity has become a sign of social status. For a variety of reasons,<sup>308</sup> poor people in the United States are more likely to be obese than middle- or upper-class people.<sup>309</sup>

Studies have shown that people make rapid assessments about others on the basis of signs and features of which they are not consciously aware. Research from the University of Aberdeen, for instance, found that large groups of women made very quick assessments about the comparative masculinity of male faces that had been altered by software to appear more or less masculine.<sup>310</sup>

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304. See *infra* notes 311–12 and accompanying text.

305. See, e.g., Harold D. Sgan-Cohen & Jonathan Mann, *Health, Oral Health and Poverty*, 138 J. AM. DENTAL ASS’N 1437, 1439–40 (2007), available at <http://jada.info/content/138/11/1437.full> (noting significance of inequalities in dental health care); Gary Taubes, *Do We Really Know What Makes Us Healthy?*, N.Y. TIMES, Sept. 16, 2007, <http://www.nytimes.com/2007/09/16/magazine/16epidemiology-t.html?pagewanted=all>.

306. Susan A. Fisher-Owens et al., *Giving Policy Some Teeth: Routes to Reducing Disparities in Oral Health*, 27 HEALTH AFF. 404 (2008), <http://content.healthaffairs.org/cgi/content/full/27/2/404> (citing P.W. Newacheck et al., *The Unmet Health Needs of America’s Children*, 105 PEDIATRICS 989 (2000)).

307. Donya C. Arias, *Children’s Dental Health Still Often Overlooked, Neglected*, NATION’S HEALTH, Mar. 1, 2008, at 7. Arias also reports on the death of Deamonte Driver, at age twelve, from an untreated tooth infection. *Id.*

308. See Janet L. Dolgin & Katherine R. Dieterich, *Weighing Status: Obesity, Class, and Health Reform*, 89 OR. L. REV. 1113 (2011) (exploring causes of correlation between weight and socioeconomic status in the contemporary U.S.).

309. WILKINSON & PICKETT, *supra* note 302, at 101; *F as in Fat: How Obesity Threatens America’s Future 2011*, TRUST FOR AMERICA’S HEALTH (July 2011), <http://www.healthyamericans.org/report/88/> (reporting that in households with incomes below \$15,000 in a year, over one-third of adults are considered obese, while in households earning over \$50,000, about a quarter of adults are considered obese). Poor people are also more likely than middle-class people to exhibit central-body adiposity. R. Rosmond, *Aetiology of Obesity: A Striving After Wind?*, 5 OBESITY REV. 177, 180 (2004).

310. Jena Pincott, *Why Women Don’t Want Macho Men*, WALL STREET J., Mar. 27, 2010, <http://online.wsj.com/article/SB10001424052748704100604575145810050665030.html>. The study was performed at the Face Research Laboratory at the University of Aberdeen in Scotland. Women

Americans use assessments of health status as markers of socioeconomic status within the same framework they use to explain poverty.<sup>311</sup> That frame has a forceful moral overlay. Signs of poor health that are linked with status are understood—as poverty is understood—as a consequence of irresponsible choices.<sup>312</sup> In short, Americans impose a moral frame on their assessments of health and class status.<sup>313</sup> The “right” choices, suggested Philip Alcabes, are read as evidence that one is “[w]orthy in the modern American moral register of health.”<sup>314</sup>

*B. Narratives of the “Other”: Poor Women, Reproductive Care, and Health Care Reform*

Such assessments reflect the nation’s opaque ideology of class. They have fueled the creation of narratives about the irresponsibility and bad choices of those who are poor. These narratives explain both poverty and poor health among those in poverty. The Affordable Care Act, a law creating more universal health care, seems likely to level differences in health status, thus upending the deeply engrained set of embodied reference points on which Americans have relied in assessing the socioeconomic status of others and of themselves in comparison.<sup>315</sup> Such changes exacerbated Americans’ anxiety about safeguarding their comparative socioeconomic status. And the current recession further exacerbated this anxiety.

No opponents of health care reform openly referred to the anxiety about losing ground in the competition for health status and thus for socioeconomic status. Yet, much of the opposition to expanding health care at public expense made that assumption. Many opponents voiced anger about the use of public funds to care for people who, they argued, did not contribute adequately to the public purse.<sup>316</sup> Thus, they saw development of universal or near-universal health care as an unfair reallocation of the nation’s resources, and they worried that their relative socioeconomic

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were shown pairs of male faces, almost imperceptibly altered. The faces were made to look more masculine by rendering them broader and shorter and giving them stronger jaws and cheekbones. *Id.*

311. See Dolgin & Dieterich, *supra* note 308.

312. *Id.*

313. *Id.*

314. Philip Alcabes, *What Ails Public Health?*, CHRON. HIGHER EDUC., Nov. 9, 2007, at B6.

315. See *supra* Part V.A.

316. Responses to expansion of the State Children’s Health Insurance Program in the last years of the Bush administration reflect this pattern. An online commenter who opposed providing additional health care coverage to low-income children explained that that approach stood in conflict with the nation’s assumption that “[w]e all have to labor for what we want.” Dr. Coles, Comment to *Democrats Begin SCHIP Veto Override Campaign*, WASH. POST, Oct. 3, 2007, [http://voices.washingtonpost.com/capitol-briefing/2007/10/democrats\\_begin\\_schip\\_veto\\_ove.html](http://voices.washingtonpost.com/capitol-briefing/2007/10/democrats_begin_schip_veto_ove.html).

status would fall as those below them gained access to health care as a result of the reforms.<sup>317</sup>

These suggestions harmonize with work recently reported by a group of economists who documented and attempted to explain an aversion to the redistribution of resources often found among those in low-income groups.<sup>318</sup> Ilyana Kuziemko and her collaborators, for instance, explored what they call a “last-place aversion.”<sup>319</sup> They reported that opposition to an increase in the nation’s minimum wage is strongest among those making slightly more than the minimum wage.<sup>320</sup> We suggest that much of the opposition to the Affordable Care Act is grounded on a similar fear of slipping in relative status—a fear that trumps support for promised increases in resources for everyone.

In the months surrounding passage of the Affordable Care Act, public attention focused on two groups of people considered unworthy of the benefits of expanded health care coverage. The first group—undocumented immigrants—was completely excluded from the reach of the Affordable Care Act.<sup>321</sup> The second group—poor women needing reproductive care—was excluded as well, but less completely and less explicitly.<sup>322</sup> These women seem to be included among those covered by the Act, but the political process has been insensitive to their actual needs. Each group became the protagonist of a set of narratives that justified that group’s marginal status within the American social order and thus within the universe of health care reform.

Shortly after Congress began actively to debate details of a health care reform law, then Chair of the Senate Finance Committee, Democratic Montana Senator Max Baucus, exclaimed that no national health care system that might emerge from congressional debate would include coverage for “undocumented aliens [or] undocumented workers.”<sup>323</sup> Such coverage, Baucus further explained, would be “too politically explosive.”<sup>324</sup> The emotional intensity that attended this issue reflected a narra-

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317. See Janet L. Dolgin, *Class Competition and American Health Care: Debating the State Children’s Health Insurance Program*, 70 LA. L. REV. 683, 729–40 (reviewing responses of opponents of expanded health care to low-income Americans at public expense).

318. See Ilyana Kuziemko et al., “Last-Place Aversion”: *Evidence and Redistributive Implications* (Nat’l Bureau of Econ. Research, Working Paper No. 17234, 2011), available at [http://www.princeton.edu/~kuziemko/lpa\\_draft\\_3june2011.pdf](http://www.princeton.edu/~kuziemko/lpa_draft_3june2011.pdf).

319. *Id.*

320. *Id.* at 30–33.

321. See *infra* notes 323–28 and accompanying text.

322. See *supra* Part IV.A.

323. Jim Landers, *Senator Says Health Insurance Plan Won’t Cover Illegal Immigrants*, DALL. MORNING NEWS, May 22, 2009, at A3.

324. *Id.* In the fall of 2009, South Carolina Republican Representative Joe Wilson shouted “you lie” at President Obama, who had just explained to both houses of Congress that “those who

tive of the “Immigrant Other” as a usurper of benefits presumed to belong to citizens.<sup>325</sup> Depriving undocumented immigrants of the right to participate in a more universal system of health care coverage reaffirmed stigmatizing images of these immigrants, many Hispanic.<sup>326</sup> Undocumented immigrants were marked as an out-group,<sup>327</sup> considered undeserving and marginal.<sup>328</sup>

As undocumented immigrants became the out-group, deprived of participation in health care reform altogether, poor women with reproductive capacity became the out-group *within*. These women were not expressly excluded from coverage, but they were to be denied a set of needed benefits that, if provided, might significantly level disparities between them and other people. Societal narratives that depict poor women as prone to bad choices,<sup>329</sup> as being insubordinate,<sup>330</sup> expensive, and even “hookers,” support their marginalization.<sup>331</sup>

Within this setting, the politics of abortion has often served multiple ends.<sup>332</sup> As the Obama administration agreed to restrict funding for abortion under the Act in exchange for promises from pro-life members of Congress to vote for the Act, it might have seemed as if the two matters—the politics of abortion and health care reform—were discrete, linked only by the happenstance of a bargain. In fact, they had become deeply entwined. The longstanding flexibility of abortion politics in the United States facilitated incorporating discomfiting assumptions about

are here illegally” would not benefit from health care reform. Michael Scherer, “*You Lie!*”: *Representative Wilson’s Outburst*, TIME MAG., Sept. 10, 2009, <http://www.time.com/time/politics/article/0,8599,1921455,00.html>. See also Janet L. Dolgin & Katherine R. Dieterich, *When Others Get Too Close: Immigrants, Class, and the Health Care Debate*, 19 CORNELL J.L. & PUB. POL’Y 283, 312–13 (2010).

325. See Dolgin & Dieterich, *supra* note 324, at 316–17.

326. See Susan T. Fiske, *Are We Born Racist?*, 5 GREATER GOOD 14, 14 (2008) (noting that prejudice against Mexican immigrants in the U.S. was more transparent than most prejudice in the first decade of the twenty-first century).

327. *Id.* at 15–16.

328. See generally Dolgin & Dieterich, *supra* note 324.

329. Rickie Solinger, *Poisonous Choice*, in “BAD” MOTHERS: THE POLITICS OF BLAME IN TWENTIETH-CENTURY AMERICA, *supra* note 23, at 386.

330. SOLINGER, *supra* note 75, at 223.

331. Katha Pollitt, *After Budget Showdown, Women Under the Bus*, THE NATION, Apr. 14, 2011, <http://www.thenation.com/article/159948/after-budget-showdown-women-under-bus>.

332. Those opposing abortion garnered the support of the pro-life movement and a large swath of the newly powerful Tea Party movement, which had played a significant role in electing the 112th Congress. Ed Kilgore, *Abortion and the Tea Party*, NEW REPUBLIC, Sept. 16, 2010, <http://www.tnr.com/blog/jonathan-cohn/77748/abortion-and-the-tea-party-ed-kilgore> (noting importance of abortion in right-wing politics in the 2010 election season); see also *The Tea Party and Religion*, PEW FORUM ON RELIGION & PUBLIC LIFE (Feb. 23, 2011), <http://www.pewforum.org/Politics-and-Elections/Tea-Party-and-Religion.aspx> (summarizing origin and positions of Tea Party).

class and its significance. Furthermore, the cloak of abortion politics facilitated voicing, while downplaying, these assumptions.

In this complicated debate about abortion, class status, and the implications of expanding health care coverage, poor women were both protagonists and victims. To the extent that the implementation of the Affordable Care Act fails to provide adequate reproductive health care for poor women,<sup>333</sup> it will exacerbate inequalities for poor women of childbearing age.<sup>334</sup> Under the Act, poor women emerge again and again as the marginalized “Other,”<sup>335</sup> against whom others can assess their own relative status.

## VI. CONCLUSION

Limits on funding for reproductive care reinforce the socioeconomic marginality of poor women. Legislators’ justifications for such limits based on budgetary concerns are largely misleading.<sup>336</sup> As we have argued, defunding family-planning services ultimately costs the nation money.<sup>337</sup> Some proponents of such defunding justify it through reference to clinics’ abortion services. But defunding family-planning services and abortion coverage does not actually decrease the number of abortions performed.<sup>338</sup>

This Article suggests that other concerns underlie efforts to limit funding for reproductive care,<sup>339</sup> and that these concerns stem from with-

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333. Cuts in abortion funding under the Affordable Care Act and pursuant to the President’s Executive Order affected all women. The consequences, however, will inevitably be far harsher for women who cannot afford abortions with personal funds. See Dehlendorf & Weitz, *supra* note 18, at 416 (“[L]ack of financial support for abortion care is a significant barrier for disadvantaged women.”).

334. See Jennifer Keighley, *Health Care Reform and Reproductive Rights: Sex Equality Arguments for Abortion Coverage in a National Plan*, 33 HARV. J.L. & GENDER 357, 397 (2010) (concluding that preclusion of coverage for abortion safeguards an *unequal* health care system).

335. The term “Other” is here used to designate a socially marginal group, defined in contrast with insiders (the “Self”). A society’s notions of Self and Other appear in its “systems of law, religion, customs, social structures, and mentality.” Mauss, *supra* note 286, at 3.

336. Charlotte Tucker, *Reproductive Health Care for Women Threatened in New Congress: Title X in Jeopardy*, NATION’S HEALTH, Apr. 1, 2011, at 1, 3.

337. Adam Sonfield & Rachel Benson Gold, Editorial, *Holding on to Health Reform and What We Have Gained for Reproductive Health*, 83 J. CONTRACEPTION 285, 287 (2010), available at <http://www.arhp.org/publications-and-resources/contraception-journal/april-2011-1>. For each taxpayer dollar going to contraceptive care, almost four times that amount is saved. *Id.* (“[P]ublicly funded family planning saves taxpayers \$3.74 for every \$1 spent providing contraceptive care.”).

338. Tucker, *supra* note 336, at 1 (noting that those favoring cuts in funding for family-planning services contend that the funds in question may indirectly support abortions by freeing money for abortions that clinics would otherwise spend on contraceptive services).

339. See, e.g., Johnson, *supra* note 242 (quoting Toni Bond Leonard of the Black Women for Reproductive Justice, saying in response to an anti-abortion campaign: “They want to make this about abortion, but this is about health disparities”).

in and serve an opaque class ideology that consistently befuddles attempts to discern relative class status. Within that ideology, blame for poverty is placed on the poor, which creates significant tension among those fearful of falling in relative class status. In response, they construct a set of groups that can be identified easily as occupying the bottom rungs of the nation's socioeconomic ladder. We do not argue that "pretexts," such as budget worries and the politics of abortion, are not real. Only pretexts that are also real serve the "texts" whose interests they voice. The primary text is about class anxiety, primarily manifested as a fear of falling in relative socioeconomic status.<sup>340</sup> That fear has been rendered more pressing in the context of the recession that began in 2008. And it has been intensified by passage of the Affordable Care Act, which promises or threatens (depending on perspective) to level disparities in health care coverage. To many of those who opposed health care reform, the Act challenges precious cultural assumptions about how one safeguards one's own socioeconomic status and how one assesses the status of others in comparison to one's own.

This Article has contextualized and illustrated the process through which people actualize these assumptions in the United States. In particular, preserving an image of a socioeconomic "Other" supplies a barometer for locating and assessing status. Poor women, deprived of funding for needed reproductive care, become an easy target for depiction as the "Other" *within*. On the surface, they were granted the right to participate fully in national health care reform (in contrast, for instance, with undocumented immigrants who were excluded completely), but without the actual services that *they* themselves need, poor women are unlikely to flourish and thus are unlikely to become competitors on the nation's class ladder.

The harm to poor women is clear. The harm to the nation is less clear but just as real. Significant socioeconomic inequalities create less stable and less successful societies than those characterized by comparative equality between people at the top and people at the bottom.<sup>341</sup> Societies with wide disparities in class status are also characterized by high levels of ill-health and social problems.<sup>342</sup> Japan, Sweden, Finland, and

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340. Sara J. Solnick & David Hemenway, *Are Positional Concerns Stronger in Some Domains Than in Others?*, 95 AM. ECON. REV. 147, 150 (2005) (reporting on importance of "positional concerns" in assessing class); *see also* Luttmer, *supra* note 293, at 965–66 (noting that "self-reported happiness" correlates with "relative income" as compared with one's neighbors more than with "absolute income"); Scott & Leonhardt, *supra* note 290 (noting decreasing likelihood during previous three decades that people in the U.S. would rise in class status).

341. Daniel Akst, *Income Inequality Hounds U.S.*, NEWSDAY (Dec. 10, 2010), <http://www.newsday.com/opinion/oped/income-inequality-hounds-u-s-1.2533893>.

342. WILKINSON & PICKETT, *supra* note 302, at 9–24.



many other countries characterized by comparative socioeconomic equality possess significantly better health and have fewer social problems than the United States.<sup>343</sup> All of these countries—including the United States—have adequate resources with which to provide health care for everyone.<sup>344</sup> But this goal cannot be achieved in the United States as long as the nation, even as it presumes to expand health care coverage, generally insists on categorizing some people as unworthy of enjoying full health care coverage and, more particularly, on characterizing poor women as the “Other” within.

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343. *Id.* at 20.

344. *Id.* at 29.