

ARTICLES

AND DAMNED IF THEY DON'T: PROTOTYPE THEORIES TO END PUNITIVE POLICIES AGAINST PREGNANT PEOPLE LIVING IN POVERTY

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INTRODUCTION

My husband and I have five children. We love kids and we love having a big family. But when my husband got laid off from his contractor job, having a big family got really hard. When I found out I was pregnant again, it was terrifying. We love the idea of another child—but we love the children we have too much to add that kind of stress to our family right now. I’m only working part-time and I couldn’t get maternity leave, so I might not be able to keep my job with another little one . . . [T]hen we had to find the money to pay for an abortion. We started taking stuff to the pawn shop: our vacuum cleaner, my wedding ring, our family television, the old desktop computer. When that wasn’t enough, we took my husband’s tools and his drills . . . We’ll be paying for this abortion for a long time.¹

Growing numbers of people living in poverty in the United States still do not have the public support they need to decide freely² whether to have a child or to parent the children they have in dignity and security. Oppressive public policies and criminal justice practices must change, and necessary enabling conditions must materialize, in order for those living in poverty³ to realize reproductive rights and justice.⁴

1. Erin Kate Ryan, *National Network of Abortion Funds: Website Redesign and Storytelling*, BEHANCE, <https://www.behance.net/gallery/1806769/National-Network-of-Abortion-Funds-storytelling>.

2. *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (declaring “the decision whether to bear or beget a child” is fundamental).

3. This term describes people who do not have sufficient income to cover all of their basic needs, and therefore may experience food or housing insecurity, rely on cash aid or other public benefits, and experience unmet needs for health care and other necessities. See, e.g., *Working Definitions*, CLASS MATTERS, http://www.classmatters.org/working_definitions.php (last visited Feb. 11, 2017). Many people who do not live in poverty, including middle class families, may nevertheless have a difficult time accessing abortion and other reproductive health care, but the Article focuses on people who are living in poverty. We also note that the federal definition of poverty is woefully insufficient, often characterizing people who struggle to make ends meet as “low income” instead of “living below the poverty line.”

4. A prescient group of women of color activists situated reproductive health within a social justice framework and coined the term “reproductive justice” after returning from the 1994 International Conference on Population and Development in Cairo, Egypt. Inspired by principles of international human rights and interested in their domestic application, the founders envisioned a movement in the U.S. that concentrated on the complete economic, social, and political empowerment of marginalized populations, namely girls and women of color. See Cynthia Soohoo & Suzanne Stolz, *Bringing Theories of Human Rights Change Home*, 77 *FORDHAM L. REV.* 459, 497 (2008) (citing Loretta J. Ross, *Understanding Reproductive Justice*, SISTERSONG: WOMEN OF COLOR REPROD. HEALTH COLLECTIVE (2006), https://d3n8a8pro7vhmxc.cloudfront.net/rrfp/pages/33/attachments/original/1456425809/Understanding_RJ_Sistersong.pdf?1456425809). See generally A NEW VISION FOR ADVANCING OUR

The legal system ought to consider the cumulative impacts (of oppressive public policies and criminal justice practices), which are compounded by other intersecting forces from the perspective of those most affected; instead the current system examines policies and practices in isolation—detached from legal impositions—and from the perspective of the enacting or enforcing powers.⁵ Government regulations that limit options and exploit vulnerabilities at one point on the spectrum of possible reproductive experiences have both immediate and delayed repercussions for other points on the spectrum, affecting nearly every realm of a person's life, livelihood, and wellbeing. At every turn, systems and institutions may open or close doors of opportunity, based on a person's real or perceived race, gender, income level, age, immigration status, and other identities or conditions.

This Article has two parts. Part I describes three ways the State coerces or impedes the reproductive decisions of people living in poverty: (1) through welfare family caps for cash aid recipients who have children; (2) through abortion coverage bans for Medicaid enrollees who need abortions; and (3) through criminal prosecutions for people who end their own pregnancies.⁶ These impediments are connected on many levels: from their ideological underpinnings, to their real-world repercussions, to their opponents' motivations to end them.

Part II reviews some of the relevant case law on welfare family caps, abortion coverage bans, and self-induced abortion, and highlights legal theories and arguments that have the potential to eventually reinstate newborn eligibility for cash aid, bolster efforts⁷ to restore abortion coverage,⁸ and improve legal circumstances for those who end their own pregnancies. Thought leaders in

MOVEMENT FOR REPRODUCTIVE HEALTH, REPRODUCTIVE RIGHTS AND REPRODUCTIVE JUSTICE, ASIAN COMMUNITIES FOR REPROD. JUSTICE (2005), <http://strongfamiliesmovement.org/assets/docs/ACRJ-A-New-Vision.pdf> (discussing the distinctions among reproductive rights, reproductive health, and reproductive justice).

5. See Kimberlé Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color*, 43 STAN. L. REV. 1241, 1242–44 (1991) (discussing how the intersectionality theory operates).

6. It is not merely criminal convictions for self-induced abortion that are problematic. The law also needs to offer better protections for people who end their own pregnancies. A person who ends their own pregnancy also needs access to safe and effective methods and means for abortion, the support of their chosen company, and a backup plan that includes support from the medical community in the event of complications. As we discuss in Part II, there are a number of other ways the law can better protect people who end their own pregnancies. See *infra* Part II.C.2.

7. There are efforts underway outside of the legal arena to restore full insurance coverage of abortion, reimagine abortion access that is more self-directed, and end welfare family caps. The authors of this article aspire to support these advocacy efforts by providing legal fodder for advocates and scholars to develop the necessary social science, legal, and public health research required to bring these legal theories to the forefront.

8. The Supreme Court's jurisprudence in *Harris v. McRae* upheld a restriction on Medicaid coverage of abortion, but there is nothing about the *McRae* decision that makes it untouchable or unchangeable. See generally Jill E. Adams & Jessica Arons, *A Travesty of Justice: Revisiting Harris v. McRae*, 21 WM. & MARY J. WOMEN & L. 5 (2014), <http://scholarship.law.wm.edu/wmjowl/vol21/iss1/3>.

academia and advocacy offer these ideas—some nascent and some novel—for further exploration.

I. DAMNED IF THEY DO AND DAMNED IF THEY DON'T: HOW THE POOR GET PUNISHED FOR REPRODUCTIVE DECISIONS

Pregnant people⁹ living in poverty or receiving public benefits are damned if they want to have an abortion and damned if they want to have a child. As Laura M. Friedman has commented, low-income people in the U.S. are shamed, constrained, and punished for their reproductive decisions by policies and cultural mores. “First, they are disdained for their poverty. Next, they are effectively told they are not worthy of having children. Finally, they face society’s moral judgments about abortion in the form of its limited availability.”¹⁰ In this section, we will discuss how the state has impeded¹¹ the reproductive rights of people living in poverty by imposing barriers that interfere with decision-making and rob people of dignity and security. Public policies and practices have combined to cause compounding harms that hamstring low-income people in pursuit of their reproductive rights. And of course, people of color and immigrants receive the additional harm of being penalized based on a racist stereotype about their worthiness and fitness as parents.¹²

9. Women, transgender men, intersex, non binary, and many other people can get pregnant. In order to ensure everyone can have legal and logistical access to abortion care, the authors use gender-neutral terms and inclusive terminology whenever possible. This includes the use of “they” and “their” as third-person singular pronouns. However, most research relating to reproductive health, pregnancy, and abortion has primarily used gendered language. Therefore, in order to most accurately represent that information, we apply the original language when necessary.

10. Laura M. Friedman, *Family Cap and the Unconstitutional Conditions Doctrine: Scrutinizing a Welfare Woman’s Right to Bear Children*, 56 OHIO STATE L.J. 637, 659–63 (1995).

11. The idea that government must not only avoid creating impediments to reproductive health, but is responsible for fulfillment of factors necessary to support good reproductive health, including removing impediments to reproductive health that were not directly created by the government, has its roots in human rights jurisprudence. For a discussion of how the human rights frame has been applied to reproductive and sexual health, see generally REBECCA J. COOK, BERNARD M. DICKENS & MAHMOUD F. FATHALLA, *REPRODUCTIVE HEALTH AND HUMAN RIGHTS* (2003); Lance Gable, *Reproductive Health as a Human Right*, 60 CASE W. RES. L. REV. 957 (2010).

12. Due to the structural inequalities in the U.S., income inequality is tethered to racism and sexism, meaning that people of color with the capacity to become pregnant are disproportionately impacted by these three policies. See Christine Dehlendorf et al., *Disparities in Abortion Rates: A Public Health Approach*, 103 AM. J. PUB. HEALTH 1772 (discussing the underlying influences on the disparities in abortion rates); Lucy A. Williams, Note, *Dethroning the Welfare Queen: The Rhetoric of Reform*, 107 HARV. L. REV. 2013, 2019 (1994). For example, people of color and immigrants comprise the majority of Medicaid enrollees. See Heather D. Boonstra, *Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters*, 16 GUTTMACHER POL’Y REV. 46, 49–50 (2016), https://www.guttmacher.org/sites/default/files/article_files/gpr1904616_0.pdf. States with higher percentages of blacks and Latinos on their welfare rolls have been significantly more likely to impose strict limits on cash aid, including family caps. See Joe Soss et al., *The Hard Line and the Color Line: Race, Welfare, and the Roots of Get-Tough Reform, in RACE AND THE POLITICS OF WELFARE REFORM* 225, 225–53 (Sanford F. Schram et al. eds., 2003). See generally NAT’L P’SHIP FOR WOMEN & FAMILIES, *A DOUBLE BIND: WHEN STATES DENY ABORTION COVERAGE AND FAIL TO SUPPORT EXPECTING AND NEW PARENTS* (2016),

When people living in poverty try to pursue the reproductive decisions that are best for them, they can become destitute, injured, or imprisoned. Even if they are able to make the decision they think is best, the process is often fraught with politically-imposed confusion, shame, and fear. For reproductive rights to be a meaningful reality, decision-making processes and outcomes must uphold the pregnant person's dignity, maintain their security, and respect their volition.

Reproductive justice advocates aim to alter the way society views, and the State governs, low-income people's reproductive decisions, ushering in a new era of government accountability to ensure all people's ability to exercise their reproductive rights.

A. CASH AID RECIPIENTS WHO BEAR CHILDREN

For all the benefits of childrearing, there are also costs, particularly financial costs that may decrease families' per capita resources and increase their poverty with each additional child born. Studies show when families living on the verge of poverty have a new baby, nearly thirteen percent will be living in poverty within a month.¹³ The likelihood of entering poverty after the birth of a new baby is higher for persons in households with more children¹⁴ or if a female is the head of the household.¹⁵

And, if the pregnant person lives in a state with a welfare family cap, the child they bear may be ineligible for cash aid.¹⁶ Welfare family caps are policies that prohibit cash aid eligibility for children born into families already receiving aid.¹⁷

<http://www.nationalpartnership.org/research-library/repro/abortion/a-double-bind.pdf> [hereinafter A DOUBLE BIND].

13. A DOUBLE BIND, *supra* note 12, at 3.

14. SIGNE-MARY MCKERNAN & CAROLINE RATCLIFFE, URBAN INST., EVENTS THAT TRIGGER POVERTY ENTRIES AND EXITS 18 (2002), <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/410636-Events-that-Trigger-Poverty-Entries-and-Exits.PDF>. See generally AMY TRAUB ET AL., DEMOS, THE PARENT TRAP: THE ECONOMIC INSECURITY OF FAMILIES WITH YOUNG CHILDREN (2016), <http://www.demos.org/sites/default/files/publications/Parent%20Trap.pdf> (discussing how having young children may impact earnings of families).

15. JASMINE TUCKER & CAITLIN LOWELL, NAT'L WOMEN'S LAW CTR., INCOME SECURITY & EDUCATION NATIONAL SNAPSHOT: POVERTY AMONG WOMEN & FAMILIES, 2015 (Sept. 2016), <http://nwlc.org/wp-content/uploads/2016/09/Poverty-Snapshot-Factsheet-2016.pdf> (concluding female-headed households with children have a poverty rate of 36.5%).

16. ANN ROSEWATER, U.S. DEP'T OF HEALTH & HUM. SERVS., *Table III: Family Cap Policies by State*, in SETTING THE BASELINE: A REPORT ON STATE WELFARE WAIVERS (June 1, 1997), <https://aspe.hhs.gov/report/setting-baseline-report-state-welfare-waivers> [hereinafter SETTING THE BASELINE].

17. See, e.g., ARIZ. REV. STAT. ANN. § 46-292(H)(1) (West, Westlaw through 2d Reg. Sess. 52d Leg. (2016)); ARK. CODE R. 208.00.1-2361 (West, Westlaw through Ark. Reg. Vol. XL, No. 7, Jan. 2017); CONN. GEN. STAT. ANN. § 17b-112(d)(2) (West, Westlaw through Gen. Stats. of Conn., Revision of 1958, revised to Jan. 1, 2017); 16 DEL. ADMIN. CODE 5100-3008.2 (West, Westlaw through Del. Reg. of Regulations Vol. 20, Issue 7, Jan. 1, 2017); FLA. ADMIN. CODE R. 65A-4.214 (West, Westlaw through Jan. 23, 2017); GA. COMP. R. & REGS. 290-2-28-.15 (West, Westlaw through Dec. 20, 2016); IDAHO ADMIN. CODE R. 16.03.08.248 (West, Westlaw through amends. in Idaho Admin. Bulletin, Vol. 16-12, Dec. 7, 2016); 470 IND. ADMIN. CODE 10.3-9-2 (West, Westlaw through amends. through Ind. Weekly Collection, Jan. 18, 2017); 106 MASS. CODE REGS. 203.300 (West, Westlaw through Dec. 16, 2016); MISS. CODE ANN. § 43-17-5(1) (West, Westlaw through Jan. 18, 2017); N.J. STAT. ANN. § 44:10-61(a) (West, Westlaw

Nearly half of the states enacted welfare family caps in the mid-1990's after welfare reform invited states to maintain¹⁸ or enact family cap policies without federal oversight.¹⁹ Today, seventeen states employ some form of welfare family cap.²⁰ These caps include: a flat rate cap (Idaho and Wisconsin), where a family receives the same amount, regardless of how many kids are in the family; a reduced grant increase (Connecticut, Florida), where a family receives a reduced grant amount for any new children conceived after the parents enrolled in welfare; a limited benefit for children conceived after the parents enrolled in welfare (South Carolina), where any children conceived after the parents enrolled in welfare receive only food and clothing vouchers; or (as in all remaining states) the state denies any grant increase for families with children conceived after welfare enrollment.²¹

If a family's aid is capped, they must then try to take care of more people with fewer resources to go around, essentially rendering the family poorer and more vulnerable to various forms of insecurity and instability.

Most welfare recipients live in dire poverty, even with public assistance. The average family of three that qualified for assistance received \$429 in cash aid per month in 2015, a benefit level that puts them at 26% of the Federal Poverty Level (FPL).²² Even with the support of cash assistance, families frequently cannot afford to take care of their daily needs.²³ Studies also show the potential increase

through L.2016, c.83 & J.R. No. 11); N.C. GEN. STAT. ANN. § 108A-27.9 (West, Westlaw through the end of the 2016 Reg. Sess., with the addition of S.L. 2016-126 from the 2016 4th Extra Sess. and through 2017-1 of the 2017 Reg. Sess.) (implemented by N.C. Dep't of Health & Human Servs., Div. of Soc. Servs., Temporary Assistance for Needy Families State Plan P.L. 104-193: The Work First Program, <https://www2.ncdhhs.gov/dss/dcdl/economicfamilyservices/EFS-WF-06-2013a.pdf>); N.D. ADMIN. CODE 75-02-01.2-30.1 (West, Westlaw through Supp. 362 (Oct. 2016)); S.C. CODE ANN. § 43-5-1175 (West, Westlaw through 2016 Sess.); TENN. CODE ANN. § 71-3-104(i) (West Westlaw through 2016 2d Reg. & 2d Extra. Sess. 109th Tenn. Gen. Assemb.); VA. CODE ANN. § 63.2-604 (West, Westlaw through 2016 Reg. Sess.); WIS. STAT. ANN. § 49.19(11s)(b) (West, Westlaw through 2015 Act 392, 4/27/2016).

18. Some states had adopted welfare family caps before welfare reform through waivers issued by the federal government. See *SETTING THE BASELINE*, *supra* note 16. As such, when welfare reform was passed in the 1990s, some states merely maintained their existing policies.

19. In 1996, President Bill Clinton signed into law the Personal Responsibility and Work Opportunity Reconciliation Act, which ushered in Temporary Assistance for Needy Families and with it the invitation for states to maintain or create welfare family caps. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (codified as amended in scattered sections of 42 U.S.C. § 1305).

20. These states are: Arizona, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Maryland, Massachusetts, Mississippi, Nebraska, New Jersey, North Carolina, South Carolina, Tennessee, Virginia, and Wisconsin. See *SETTING THE BASELINE*, *supra* note 16.

21. CTR. FOR REPROD. RIGHTS & JUSTICE, BRINGING FAMILIES OUT OF 'CAP'TIVITY: THE PATH TOWARDS ABOLISHING WELFARE FAMILY CAPS 1 (2016), https://www.law.berkeley.edu/wp-content/uploads/2015/04/2016-Caps_FA2.pdf [hereinafter *OUT OF 'CAP'TIVITY*]; see also *SETTING THE BASELINE*, *supra* note 16.

22. OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, U.S. DEPT. OF HEALTH & HUMAN SERVS., HHS POVERTY GUIDELINES FOR 2016, <https://aspe.hhs.gov/poverty-guidelines>.

23. In 14 states, a family received cash aid of less than \$300 per month. *Chart Book: TANF at 20*, CTR. ON BUDGET & POLICY PRIORITIES (Aug. 5, 2016), <http://www.cbpp.org/research/family-income-support/chart-book-tanf-at-20>.

in a capped family's cash grant is not enough to incentivize childbearing, much less enough to lift a family out of poverty, though it does make a difference in the family's ability to function. Thus, a pregnant person whose cash aid will be capped may decide they need to have an abortion,²⁴ while others will carry their pregnancy to term and try their best to do more with less. Either way, it should not be a government policy or program that drives that decision.²⁵

B. MEDICAID PATIENTS WHO NEED ABORTIONS

Since carrying a pregnancy to term can push a person or their family deeper into poverty, it is not surprising that 40% of people seeking an abortion reported needing one because they did not feel financially prepared to have a baby.²⁶ Respondents in one study of people who, for a variety of reasons, were unable to have an abortion in a clinic cited general financial concerns ranging from "It all boils down to money" to "can't afford to support a child" to "I didn't have money to buy a baby spoon."²⁷ The study's subjects often sought abortion because they were unemployed, underemployed, uninsured, or could not get or did not want public assistance.²⁸ Additionally, people who were unable to secure abortion care were less likely to be working full-time one year later than people who were able to obtain the care they needed.²⁹

In other words, pregnant people often seek abortion because they cannot afford to have a child, but the cruel paradox is that many cannot afford to have an abortion either. The inability to access abortion exacerbates the poverty that prompted them to need an abortion in the first place. When a pregnant person seeks but is unable to secure an abortion and is then forced to carry a pregnancy to term, they are more likely to be living in poverty two years later than a

24. Of course, financial reasons are not the only reasons people seek abortions or decide to start or expand a family. In fact, most people report multiple reasons for having an abortion. *See generally, e.g.,* M. Antonia Biggs et al., *Understanding Why Women Seek Abortions In The U.S.*, BMC WOMEN'S HEALTH (July 5, 2013), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3729671/pdf/1472-6874-13-29.pdf>; Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 PERSP. ON SEXUAL & REPROD. HEALTH 110, 110–18 (2005), https://www.guttmacher.org/sites/default/files/article_files/3711005.pdf; Sarah C.M. Roberts et al., *Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States*, 24 WOMEN'S HEALTH ISSUES 211, 211–18 (2014), [http://www.whijournal.com/article/S1049-3867\(14\)00004-8/pdf](http://www.whijournal.com/article/S1049-3867(14)00004-8/pdf).

25. Of course, removing impediments on reproductive health is only a floor and not a ceiling. Government ought to support people with realizing these reproductive health rights.

26. *See* REPRODUCTIVE HEALTH TECHNOLOGIES PROJECT, TWO SIDES OF THE SAME COIN: INTEGRATING ECONOMIC AND REPRODUCTIVE JUSTICE 1, 13 (Aug. 2015), <http://rhtp.org/wp-content/uploads/2016/08/Two-Sides-of-the-Same-Coin-Integrating-Economic-and-Reproductive-Justice.pdf> [hereinafter TWO SIDES REPORT].

27. People in other studies reported housing insecurity as a reason—often living in their car or staying with friends or family. *See* TWO SIDES REPORT, *supra* note 26, at 13; Biggs, *supra* note 24, at 2.

28. TWO SIDES REPORT, *supra* note 26, at 17.

29. *See* Diana Greene Foster et al., Abstract, *Socioeconomic Consequences of Abortion Compared to Unwanted Birth*, APHA (Oct. 30, 2012), <https://apha.confex.com/apha/140am/webprogram/Paper263858.html>.

similarly financially situated person who was able to have an abortion.³⁰

A major contributing factor to abortion's unaffordability is the lack of insurance coverage for it.³¹ There are 15.6 million women of reproductive age in the U.S. who are enrolled in Medicaid for their health insurance.³² However, these women cannot use their insurance for abortion care because the Hyde Amendment bans the use of federal Medicaid funds for abortion, with exceptions for pregnancies that are life-threatening or the result of rape or incest.³³ Medicaid enrollees in the states³⁴ that do not provide abortion coverage with state Medicaid funds must cobble together the money (\$495 for a first-trimester aspiration procedure or \$500 for a medication abortion)³⁵ to pay for the service out of pocket.³⁶

30. See TWO SIDES REPORT, *supra* note 26, at 2, 14.

31. JENNI KOTTING & GRETCHEN ELY, NAT'L NETWORK OF ABORTION FUNDS, THE UNDUE BURDEN OF PAYING FOR ABORTION: AN EXAMINATION OF ABORTION FUND CASES—DATA FROM THE NATIONAL NETWORK OF ABORTION FUNDS' TILLER MEMORIAL ABORTION FUND 3 (2017), https://www.researchgate.net/profile/Gretchen_Ely/publication/313599490_The_undue_burden_of_paying_for_abortion_An_exploration_of_abortion_fund_cases_Data_From_The_National_Network_Of_Abortion_Funds'_George_Tiller_Memorial_Abortion_Fund_2010-2015/links/58b4745492851cf7ae941099/The-undue-burden-of-paying-for-abortion-An-exploration-of-abortion-fund-cases-Data-From-The-National-Network-Of-Abortion-Funds-George-Tiller-Memorial-Abortion-Fund-2010-2015.pdf ("Federal public policy in the United States restricts public funding of abortion, which is a primary cause of high out-of-pocket costs associated with abortion care. State level restrictions on abortion, which include mandatory wait periods and bans on private insurance coverage also create significant cost barriers for many seeking the procedure.").

32. *October 2016 Fact Sheet: Women's Health Insurance Coverage*, HENRY J. KAISER FAMILY FOUND. (2016), <http://files.kff.org/attachment/fact-sheet-womens-health-insurance-coverage>.

33. GUTTMACHER INST., STATE FUNDING OF ABORTION UNDER MEDICAID (Feb. 1, 2017), http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf.

34. At present, fifteen states provide state funding for abortion for Medicaid patients. *Id.* Additionally, two states, Arizona and Illinois, are under a court order to provide funding for abortion, but are not in compliance with the order. *Id.* Because it is anticipated there may be changes in the Medicaid program in the coming years, which may impact the availability of state funds for abortion, we focus our discussion on federal Medicaid funds instead of state Medicaid programs. However, it may be worth further consideration as to whether the federal government's denial of abortion coverage is a violation of federal law, even if a state Medicaid program provides funding for the abortion. *See id.*

35. Jenna Jerman & Rachel K. Jones, *Secondary Measures of Access to Abortion Services in the United States, 2011 and 2012: Gestational Age Limits, Cost, and Harassment*, 24 WOMEN'S HEALTH e419, e421, e422 (2014), <https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/j.whi.2014.05.002.pdf>. Note, however, that costs for abortions vary. The Center for Reproductive Rights interviewed women about the cost of their abortions and found one woman reported paying over \$600 for her abortion performed at sixteen weeks, while another woman reported paying over \$2,000 for an abortion at seventeen weeks, and another was charged \$1,510 for an abortion at twenty weeks. CTR. FOR REPROD. RIGHTS, WHOSE CHOICE? HOW THE HYDE AMENDMENT HARMS POOR WOMEN 22 (Sept. 30, 2010), https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Hyde_Report_FINAL_nospreads.pdf [hereinafter WHOSE CHOICE].

36. Today, far more people are forced to pay out-of-pocket for abortion care, as a result of the Hyde Amendment's spread through Medicaid expansion under the Patient Protection and Affordable Care Act (ACA), bans on abortion coverage in about half the states' ACA insurance exchanges, and some states' recent bans on abortion coverage in private insurance plans. *See* JENNA JERMAN ET AL., GUTTMACHER INST., CHARACTERISTICS OF U.S. ABORTION PATIENTS IN 2014 AND CHANGES SINCE 2008 at 9 (2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf

A pregnant Medicaid beneficiary generally has an income of no more than \$1,300 per month.³⁷ Thus, the cost of abortion treatment alone would consume over 40% of their monthly income. Tack onto that the price of bus tickets or gas, which could be expensive if they live in the center of the country where most people live more than 150 miles from the nearest clinic.³⁸ Moreover, because of state-mandated waiting periods, this person may have to come up with money for a place to stay overnight³⁹ and for childcare for the kids they had to leave behind. That is all assuming they can afford the lost wages for the days away from work.

In 2014, nearly one in ten women in the U.S. had to delay their abortion by more than two weeks, and those who did reported they had recently experienced a disruptive life event, “such as losing a job or falling behind on rent (which may lead to financial hardships that require patients to use additional time to find money for the procedure).”⁴⁰ By the time they had pulled together the money for the abortion, the cost of the abortion would almost certainly have increased.⁴¹

All told, securing an abortion can cost some families half a month's pay.⁴² Considering the fact that approximately 63% of Americans report that they do not

[hereinafter CHARACTERISTICS OF U.S. ABORTION PATIENTS] (concluding that 53% of abortion patients pay out of pocket for abortion care).

37. A person's monthly income may be considerably lower than this amount, with some Medicaid beneficiaries, particularly single people, having a monthly income of closer to \$990 per month, though some states have expanded Medicaid eligibility to allow for higher income. *See generally Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level*, HENRY J. KAISER FAMILY FOUND. (Jan. 1, 2017), <http://kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level/?current-timeframe=0>; Usha Ranji et al., *Medicaid and Family Planning: Background and Implications of the ACA*, HENRY J. KAISER FAMILY FOUND. (Feb. 3, 2016), <http://files.kff.org/attachment/issue-brief-medicaid-and-family-planning-background-and-implications-of-the-aca/>.

38. *See* Rachel K. Jones & Jenna Jerman, *How Far Did U.S. Women Travel for Abortion Services in 2008?* 22 J. WOMEN'S HEALTH 706 (2013); Michael Keller & Allison Yarrow, *The Geography of Abortion Access*, DAILY BEAST, Jan. 22, 2013, <http://www.thedailybeast.com/articles/2013/01/22/the-geography-of-abortion-access.html>.

39. This, of course, assumes the person has a car and a credit card, which would be required to secure a hotel room. For a summary of some of the other common practical barriers to securing an abortion for people living in poverty, see *What It Really Takes to Get an Abortion*, THIRD WAVE FUND (2011), <http://thirdwavefund.org/blog/what-it-really-takes-to-get-an-abortion>.

40. Rachel K. Jones & Jenna Jerman, *Time to Appointment and Delays in Accessing Care Among U.S. Abortion Patients*, GUTTMACHER INST. (Aug. 2014), <https://www.guttmacher.org/report/delays-in-accessing-care-among-us-abortion-patients#12a>.

41. Delaying abortion by a matter of days or weeks can make the cost of abortion spike from \$500 to \$2,000 or more and can narrow the number of providers who are able to perform the abortion. *See* Rachel K. Jones et al., *At What Cost? Payment for Abortion Care by U.S. Women*, 23 WOMEN'S HEALTH ISSUES 173 (2013).

42. *See, e.g., What Are the Annual Earnings for a Full-Time Minimum Wage Worker?*, CTR. FOR POVERTY RESEARCH, UNIV. OF CAL., DAVIS, <http://poverty.ucdavis.edu/faq/what-are-annual-earnings-full-time-minimum-wage-worker> (last visited Feb. 11, 2017) (at the current federal minimum wage, a person working a 40-hour week would earn \$1,150 per month after Social Security and Medicare taxes). Some other reports suggest the true cost of securing an abortion after adding in all of the ancillary costs could be as much as a full month's pay for some low wage workers. *See, e.g., Erica Hellerstein, Pricing American Women Out of Abortion, One Restriction at a Time*, THINKPROGRESS (Feb. 25, 2015), <http://thinkprogress.org/health/2015/02/25/3622531/cost-abortion-investigation/>.

have enough in savings to pay for an unexpected \$500 expense,⁴³ a pregnant person would likely have to forgo paying for rent, utilities, or food, and may have to delay their abortion until a later stage of pregnancy when costs and complexities increase.⁴⁴ As a matter of household economics, clinic-based abortion care is simply not feasible for many people in this position. Some may seek and find assistance from abortion funds in time,⁴⁵ but others will not be as fortunate.

C. PEOPLE WHO END THEIR OWN PREGNANCIES

Some people who would prefer clinic-based abortion care are unable to obtain it due to cost or because clinic-based care has been regulated out of their reach.⁴⁶ When they cannot afford abortion care at the nearest clinic, some pregnant people may turn to the internet to research less expensive alternatives to clinic-based care.⁴⁷ However, the Google search might turn up headlines about Purvi Patel,⁴⁸ Jennie Linn McCormack,⁴⁹ Kenlissia Jones,⁵⁰ and others⁵¹ arrested and impris-

43. Aimee Picchi, *Most Americans Can't Handle a \$500 Surprise Bill*, CBS MONEY WATCH (Jan. 6, 2016), <http://www.cbsnews.com/news/most-americans-cant-handle-a-500-surprise-bill/>. Only 37% of U.S. adults have enough savings to pay for these unexpected expenses. *Id.* 23% would reduce their spending on other things to make ends meet, 15% would use credit cards, and another 15% would borrow from family or friends. *Id.*

44. Abortion is one of the safest treatments in the U.S., even in the second trimester, but it is more challenging to find a provider to perform an abortion in a later stage of pregnancy, possibly requiring additional travel and expenses; delay also may make it more difficult to secure an appointment. *See* HEATHER BOONSTRA ET AL., GUTTMACHER INST., ABORTION IN WOMEN'S LIVES 14 (2006), <https://www.guttmacher.org/sites/default/files/pdfs/pubs/2006/05/04/AiWL.pdf>.

45. In 2014, some 14% of abortion patients relied on financial assistance from an abortion fund or a clinic discount. CHARACTERISTICS OF U.S. ABORTION PATIENTS, *supra* note 36.

46. It should be noted that the cost of abortion and proximity to a clinic are not the only factors for people ending their own pregnancies. As discussed below, a pregnant person may prefer to end a pregnancy in the comfort of their own home and in the safety of their chosen companion. Self-directed care may be a requirement of a belief system or an expression of values. *See infra* notes 57–62 and accompanying text.

47. DANIEL GROSSMAN ET AL., TEX. POLICY EVALUATION PROJECT, RESEARCH BRIEF: KNOWLEDGE, OPINION AND EXPERIENCE RELATED TO ABORTION SELF-INDUCTION IN TEXAS (NOV. 14, 2015), https://www.ibisreproductivehealth.org/sites/default/files/files/publications/TxPEP_KnowledgeOpinionExperience%20with%20self%20induction_Research%20Brief_17Nov2015.pdf [hereinafter KNOWLEDGE, OPINION AND EXPERIENCE] (estimating that between 100,000 and 240,000 Texas women have tried to end a pregnancy on their own without medical assistance); Daniel Grossman et al., *Self-Induction of Abortion Among Women in the United States*, 18 REPROD. HEALTH MATTERS 136, 142 (2010) [hereinafter *Self-Induction of Abortion*].

48. *See, e.g.*, Emily Bazelon, *Purvi Patel Could Be Just the Beginning*, N.Y. TIMES (Apr. 1, 2015), <https://www.nytimes.com/2015/04/01/magazine/purvi-patel-could-be-just-the-beginning.html>.

49. *See, e.g.*, Jessica Robinson, *Idaho Woman Arrested for Abortion Is Uneasy Case for Both Sides*, BOISE STATE PUB. RADIO (Apr. 11, 2012), <http://boisestatepublicradio.org/post/idaho-woman-arrested-abortion-uneasy-case-both-sides#stream/0>.

50. *See, e.g.*, *Woman Who Took Abortion Pill Charged in Death of Fetus*, CBS NEWS (June 9, 2015), <http://www.cbsnews.com/news/woman-who-took-abortion-pill-charged-in-death-of-fetus/>.

51. *See, e.g.*, Jennifer Lee & Cara Buckley, *For Privacy's Sake, Taking Risks to End a Pregnancy*, N.Y. TIMES (Jan. 4, 2009), <http://www.nytimes.com/2009/01/05/nyregion/05abortion.html> (discussing cases

oned for allegedly ending their own pregnancies. What is this person to do? They do not have the resources to take care of another child, health insurance that covers abortion, money to pay for many of the costs related to an abortion, or the funds to pay attorney's fees to avoid going to prison and losing their parental rights if they get caught trying to end the pregnancy themselves.

Abortion clinic closures do not prompt a corresponding rise in the birth rate.⁵² Resourceful people and their loved ones find ways to end pregnancies on their own, using medication,⁵³ herbs, or less safe measures.⁵⁴ For some, the self-induced abortion experience will be a positive one, occurring in a safe place through effective means while accompanied by a loved one or other trusted source of support. For others, particularly people living in poverty, immigrants, and people of color who are disproportionately targeted and arrested for pregnancy-related crimes,⁵⁵ the self-induced abortion experience may be shrouded by the fear of jail or deportation, as well as concern for themselves if they lack information about proper dosage and typical side effects.⁵⁶

In addition to the legal, practical, or financial barriers to clinic-based abortion care, there are many other reasons a person might end their own pregnancy. For some, it may be the confusing matrix of state and federal laws relating to abortion that drives them away from the formal health care system. Navigating unfamiliar and complicated systems, such as health care and insurance, can lead to misunderstanding and frustration, particularly when English is not one's first language.⁵⁷

For others, clinical care may not meet their needs because Western medicine does not typically integrate traditional treatments such as herbs, acupuncture, and

of Amber Abreu in Massachusetts and Gabriela Flores in South Carolina, who took misoprostol at home to end their pregnancies).

52. See Seth Stephens Davidowitz, *The Return of the DIY Abortion*, N.Y. TIMES (Mar. 5, 2016), http://www.nytimes.com/2016/03/06/opinion/sunday/the-return-of-the-diy-abortion.html?_r=0 (finding fewer abortions in states with the most restrictions, but also fewer live births than would be expected in these states, a phenomenon the authors describe as "missing pregnancies in parts of the country where it was hardest to get an abortion.").

53. See Francine Coeytaux et al., *Bold Action to Meet Women's Needs: Putting Abortion Pills in U.S. Women's Hands*, 26 WOMEN'S HEALTH ISSUES 608, 608–11 (2015), [http://www.whijournal.com/article/S1049-3867\(15\)00129-2/pdf](http://www.whijournal.com/article/S1049-3867(15)00129-2/pdf) [hereinafter *Bold Action*]; see also Lee & Buckley, *supra* note 51 (reporting on the many reasons people did not go to a clinic for an abortion, including "mistrust of the health-care system, fear of surgery, worry about deportation, concern about clinic protesters, cost and shame.").

54. KNOWLEDGE, OPINION AND EXPERIENCE, *supra* note 47, at 3.

55. See generally Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL. POL'Y & L. 299 (2013).

56. People will pursue abortion when they need one no matter the consequences, including arrest and deportation. See Gilda Sedgh et al., *Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008*, 379 LANCET 625, 631 (2012) (finding "some women who are determined to avoid an unplanned birth will resort to unsafe abortions if safe abortion is not readily available, some will suffer complications as a result, and some will die.").

57. See Quyen Ngo-Metzger & Michael P. Massagli, *Linguistic and Cultural Barriers to Care*, 18 J. GEN. INTERNAL MED. 44, 52 (2003).

massage.⁵⁸ A pregnant person may prefer to have an abortion in the privacy and comfort of their own home, rather than in the more public setting of a hospital or clinic.⁵⁹ They may want to be in the company of a partner, family, or friends, rather than medical professionals. Additionally, they may want to self-administer abortion pills (commonly a pharmaceutical pill called misoprostol, which is also used in clinic-based abortions),⁶⁰ vitamins, herbs, or natural remedies, because they view these methods as more natural or less physically invasive than aspiration or surgical abortion.⁶¹

Self-directed care may be a requirement of a person's belief system or an expression of values. For others, distrust of the medical establishment emanating from a history of that establishment's abuse of their communities may drive them from the formal health care system.⁶² Thus, in addition to being the only option for some, the choice to self-induce can be an expression of autonomy and a form of empowerment that ought to be respected—not criminalized.

Regardless of their reasons, if a person takes matters into their own hands, they currently (and unjustifiably) risk arrest and imprisonment under laws that limit abortion provision to licensed health care workers and that criminalize self-

58. See *id.*; see also NAT'L ASIAN PAC. AM. WOMEN'S FORUM, APA WOMEN AND ABORTION: A FACT SHEET (Mar. 2005), https://napawf.org/wp-content/uploads/2009/working/pdfs/Abortion_FactSheet.pdf. Some immigrants have reported facing negative responses from doctors for their use of traditional medicines, which may lead to rifts between doctors and patients. *Id.*

59. *Self-Induction of Abortion*, *supra* note 47, at 142.

60. *Id.* at 136.

61. *Id.* at 140–142.

62. Two examples of medical abuse are sterilization and pharmaceutical testing. In the last century, Native American, Mexican-American, African-American, and Puerto Rican women, as well as Japanese women in U.S. internment camps, endured widespread coercive or forced sterilization by the government and private doctors. Women who did not speak English were asked or coerced into signing English-only forms during labor and childbirth that authorized sterilization, while others were given hysterectomies without their knowledge. See JESSICA ARONS & MADINA AGÉNOR, CTR. FOR AM. PROGRESS, SEPARATE AND UNEQUAL: THE HYDE AMENDMENT AND WOMEN OF COLOR 21 (2010) https://cdn.americanprogress.org/wp-content/uploads/issues/2010/12/pdf/hyde_amendment.pdf [hereinafter SEPARATE AND UNEQUAL] (explaining that in the 1960s and 1970s, Medicaid physicians delivered babies and performed abortions for African-American women only if they consented to being sterilized, and, in Puerto Rico, about one-third of never-married women between ages twenty and forty-nine were sterilized by 1965); ELENA GUTIERREZ, FERTILE MATTERS: THE POLITICS OF MEXICAN-ORIGIN WOMEN'S REPRODUCTION 38–39 (Denna J González & Antonia Castañeda eds., 2008) (noting federally funded Indian Health Service (IHS) clinics pressured Native American women into undergoing sterilization, sometimes threatening the loss of public benefits); Nicole M. Jackson, *A Black Woman's Choice: Depo-Provera and Reproductive Rights*, 3 J. RES. ON WOMEN & GENDER 1, 4–5, 28, https://www.academia.edu/1498904/A_Black_Woman_s_Choice-Depo-Provera_and_Reproductive_Rights (estimating between 100,000 and 150,000 poor women in the U.S. were sterilized every year in the 1960s and 1970s using federal funds and that 43% of women sterilized in federally funded family planning programs were African-American). Additionally, the pharmaceutical industry tested early versions of long-acting reversible contraception methods (or LARCs) on African-American, low-income, and rural women fifty years ago. See COMM. ON WOMEN, POPULATION & THE ENV'T, *Sex, Lies & Birth Control: What You Need to Know About Your Birth Control Campaign*, in REPRODUCTIVE JUSTICE BRIEFING BOOK: A PRIMER ON REPRODUCTIVE JUSTICE AND SOCIAL CHANGE 8–9, <https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fID=4051>.

induced abortion under a litany of potential charges.⁶³ “[People] who cannot realistically access abortion may be forced not only to take measures that are not the safest ones available, but also, as happened to [Jennie Linn] McCormack, to hazard the additional constitutional and dignitary harm of being treated as a criminal.”⁶⁴

When the laws that criminalize self-induced abortion are considered in the context of abortion coverage bans and welfare family caps, it crystallizes just how people living in poverty are forced into an impossible situation—where the government not only fails to support their decision to carry a pregnancy to term or to get the abortion they need, it frequently penalizes them, regardless of the decision they make. Grassroots mobilization, public education, and policy advocacy efforts are already underway to improve this situation, but legal challenges are another avenue to create change. Lamentably, the extant jurisprudential tools are too few and too dull to solve these interlocking problems; new tools must be forged and sharpened.

II. THE NEW PARADIGM TO EXPAND ACCESS, OPTIONS, AND RESOURCES FOR PREGNANT PEOPLE LIVING IN POVERTY

This section focuses on possible legal challenges to welfare family caps, abortion coverage bans, and improving circumstances for people who end their own pregnancies. To illustrate approaches previously taken in federal court challenges, the article highlights one case and its reasoning for each issue. Then, it considers novel theories that—with further exploration and development by scholars and advocates—could potentially be used to end these damaging policies and practices.

A. WELFARE FAMILY CAPS

The primary motivation cited by policymakers enacting family caps was to curb childbearing by welfare recipients.⁶⁵ However, these policies have failed to affect birth rates among the affected population, as evidenced by multiple federal and state-level studies conducted over the last twenty years.⁶⁶

63. See JILL E. ADAMS, MELISSA MIKESSELL, & SIA LEGAL TEAM, CTR. ON REPROD. RIGHTS & JUSTICE, UNIV. OF CAL., BERKELEY SCH. OF LAW, PRIMER ON SELF-INDUCED ABORTION, <https://www.law.berkeley.edu/wp-content/uploads/2016/01/SIA-Legal-Team-Primer.pdf>; Andrea Rowan, *Prosecuting Women for Self-Inducing Abortion: Counterproductive and Lacking Compassion*, 18 GUTTMACHER POL'Y REV. 70, 70–76 (2015), <https://www.guttmacher.org/sites/default/files/pdfs/pubs/gpr/18/3/gpr1807015.pdf>.

64. Brief for Nat'l Advocates for Pregnant Women et al. as Amici Curiae Supporting Petitioners, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016) (No. 15-274), 2016 WL 322592, at *15.

65. OUT OF 'CAP' TIVITY, *supra* note 21, at 1–2.

66. *Id.* at 2–3 (discussing various studies demonstrating these policies have failed to achieve their proponents' purported primary objective of lowering the number of children born into families receiving public assistance); see also Jessica R. Arons, *Misconceived Laws: The Irrationality of Parental Involvement Requirements for Contraception*, 41 WM. & MARY L. REV. 1093, 1093–131 (2000)

While caps do not reduce childbearing, they do exacerbate poverty, worsen health and social outcomes, and heighten food and housing insecurity for the children born. Family caps punish low-income parents⁶⁷ who are disproportionately women of color. This comes as no surprise given that the policies emanate from racist,⁶⁸ classist, and sexist⁶⁹ stereotypes about welfare beneficiaries⁷⁰ and their reproductive motivations and behaviors; eugenics-based notions of who is worthy of reproduction; and population control motives.

1. Reflections on Precedent: *C.K. v. Shalala*

In 1992, New Jersey became the first state⁷¹ to enact a family cap⁷² as part of its welfare cash aid program, the Family Development Program (FDP).⁷³ Participants in the FDP brought a class action lawsuit, claiming the family cap policy violated their constitutional right to make decisions about conception and childbirth in a private manner, free from governmental intrusion. In *C.K. v. Shalala*,⁷⁴ the district court granted summary judgment for the defendants and upheld the policy, concluding that it did not violate plaintiffs' Due Process or Equal Protection rights under the Fifth or Fourteenth Amendments of the federal

(concluding that laws that accomplish the opposite of their purported or stated intent ought to, *ipso facto*, fail even rational review).

67. See David Steib, *Can "Family Values" Lift Americans Out of Poverty?*, 9 GEO. J. GENDER & L. 447, 456 (2008) ("[F]amily cap[s] offend fundamental concepts of justice by depriving a child of benefits, which he would normally receive, for the purpose of punishing the child's parent.").

68. See Dorothy E. Roberts, *Welfare Reform and Economic Freedom: Low-Income Mothers' Decisions About Work at Home and in the Market*, 44 SANTA CLARA L. REV. 1029, 1058–59 (2004) (concluding the impact of family policies reinforce gender, race, and class norms and stratification).

69. Gender classifications reinforce and perpetuate stereotypes of women—e.g., treating women as nonparticipants in the workforce, focusing on their primary role as mothers and nurturers, and presuming their identity is derived from their biological reproductive abilities. These stereotypes harm all people by limiting life choices through the perpetuation of stereotypical roles. See C. R. Albiston & L. B. Nielsen, *Welfare Queens and Other Fairy Tales: Welfare Reform and Unconstitutional Reproductive Controls*, 38 HOWARD L.J. 473, 474–76 (1994) [hereinafter *Welfare Queens*].

70. When New Jersey adopted the family cap, the governor at the time defended the policy by stating that "it's about accepting responsibility for your actions." Jennifer Preston, *Births Fall and Abortions Rise Under New Jersey Family Cap*, N.Y. TIMES (Nov. 3, 1998), <http://www.nytimes.com/1998/11/03/nyregion/births-fall-and-abortions-rise-under-new-jersey-family-cap.html>. In light of such statements, the question becomes whether the family cap's infliction of hardship on children is warranted by a paternalistic moral judgment made by legislators against young mothers.

71. As noted above, there are currently 17 states that have family cap statutes in place: Arizona, Arkansas, Connecticut, Delaware, Florida, Georgia, Idaho, Indiana, Massachusetts, Mississippi, New Jersey, North Carolina, North Dakota, South Carolina, Tennessee, Virginia, Wisconsin. See OUT OF 'CAP'TIVITY, *supra* note 21, at 2.

72. New Jersey's family cap prohibits eligibility for children born into families already receiving cash aid, whereas Maryland's cap, upheld in *Dandridge v. Williams*, 397 U.S. 471 (1970), set a monetary ceiling on welfare benefits irrespective of family size or need. See Susan Frelich Appleton, *Standards for Constitutional Review of Privacy-Invasive Welfare Reforms: Distinguishing the Abortion-Funding Cases and Redeeming the Undue-Burden Test*, 49 VAND. L. REV. 1, 39 (1996).

73. *Id.* (noting that the FDP family cap provides data showing that welfare ceilings do not "deter . . . birth . . . among the poor").

74. 883 F. Supp. 991 (D.N.J. 1995).

Constitution.⁷⁵ To reach the conclusion that the cap did not present an undue burden on reproductive rights, the district court explained that the policy did not condition receipt of benefits upon FDP participants' reproductive choices. According to the district court, the policy "merely removed the automatic benefit increase associated with an additional child," but did not penalize or prohibit an FDP participant from conceiving or bearing an additional child.⁷⁶

The United States Court of Appeals for the Third Circuit summarily affirmed the District Court's decision without addressing the manifold constitutional arguments raised by plaintiffs and amici.⁷⁷ It did observe, though, "that it would be remarkable to hold that a state's failure to subsidize a reproductive choice burdens that choice."⁷⁸ Despite another legal challenge under the state constitution⁷⁹ and legislative advocacy,⁸⁰ New Jersey's family cap remains in place today.⁸¹

2. New Approaches for Future Strategies

Welfare family caps prompt questions about the permissibility of the State shaping its public benefits programs in a manner that injects its preference into a reproductive decision-making process (i.e. the right to procreate) that would otherwise be constitutionally protected.⁸² In this section we propose two theories

75. *Id.* at 1013–15.

76. *Id.* at 1015 (relying on *Harris v. McRae*, 448 U.S. 297 (1980)).

77. *C.K. v. N.J. Dep't of Health & Human Servs.*, 92 F.3d 171, 195 (3d Cir. 1996); Stefanie Paige Underwood, *C.K. v. N.J. Dep't of Health & Human Servs.: The War on Welfare Mothers*, 18 *WOMEN'S RTS. L. REP.* 343, 349 (1997).

78. *C.K.*, 92 F.3d at 195.

79. In 1997, the American Civil Liberties Union of New Jersey and National Organization for Women's Legal Defense and Education Fund filed *Sojourner A. v. N.J. Dep't of Human Servs.*, challenging the FDP family cap on equal protection and right to privacy grounds under the state constitution. The trial court upheld the statute, finding that while the child exclusion policy might impose a "slight" burden on a woman who chose to have an additional child, it did not "substantially intrude" on her reproductive autonomy. 794 A.2d 822, 824, 825, 834 (N.J. Super. Ct. App. Div. 2002), *sub nom.* 828 A.2d 306 (N.J. 2003) (discussing and upholding the unpublished trial court decision).

80. Assemb. Bill 3410, 217th Leg. (N.J. 2016); *see also* GOV. CHRIS CHRISTIE, VETO MESSAGE FOR A. 3410 (June 30, 2016), <http://nj.gov/governor/news/news/552016/pdf/20160630c/A3410AV.PDF> [hereinafter VETO MESSAGE].

81. *See* Bryce Covert, *Chris Christie Rejects Effort To Repeal Racist, Sexist Welfare Rule*, OXIMITY (July 5, 2016), <https://www.oximity.com/article/Chris-Christie-Refuses-To-End-Racist-S-1>; *see also* VETO MESSAGE, *supra* note 80.

82. Scholarship has suggested welfare family caps could also be challenged under the Equal Protection Clause as gender classification that reinforces and perpetuates stereotypes of women. *See* Cara C. Orr, *Married to a Myth: How Welfare Reform Violates the Constitutional Rights of Poor Single Mothers*, 34 *CAP. U. L. REV.* 211, 247–48 (2005–2006). Others have argued that uneven infringement of a fundamental right also make family caps ripe for challenge. *See Welfare Queens*, *supra* note 69; Steib, *supra* note 67, at 455–56 (commenting that the Court's rationale in *Dandridge* is questioned in *Plyler v. Doe*, where Justice Brennan, addressing public benefits for undocumented families states, "[E]ven if the State found it expedient to control the conduct of adults by acting against their children, legislation directing the onus of a parent's misconduct against his children does not comport with fundamental conceptions of justice."). Additionally, because some social science data suggests welfare family caps have disparate impacts on black and Latino families, these laws may be motivated by racial animus. *See*

for challenging welfare family caps: (1) the unconstitutional conditions doctrine and (2) an intersectional disparate impacts analysis.

a. Unconstitutional Conditions Doctrine. The State can generally determine how it allocates its largesse, including how much money to give away through social safety net programs and the criteria for eligibility.⁸³ Once it decides to provide a certain public benefit, though, it must do so within constitutional limits.⁸⁴ While the government can mold public programs to reflect, or even promote, its own interests, it cannot go so far as to shape them in a way that prohibits or punishes people for exercising their constitutionally protected rights. It cannot set benefit conditions that penalize people for protected activities or force them to relinquish their rights in order to receive the benefit.⁸⁵ In essence, the State cannot use public benefits programs to accomplish indirectly what it could not do directly. Courts often employ the doctrine of unconstitutional conditions⁸⁶ to examine such benefit conditions.⁸⁷ While the doctrine's applica-

id. at 456 (concluding that a “black woman who conceives a child while receiving welfare is now less likely than a white woman to live in a state that offers additional aid for the child,” and noting how systems that convey a sense of inferiority based on race have a detrimental affect on the hearts and minds of children, an effect that is unlikely to ever be undone). Others have suggested caps could discriminate on the basis of birth status, which should be subject to heightened review. *See* Appleton, *supra* note 72, at 37–43. Lastly, there may be a basis to challenge family caps as an unconstitutional taking of private property without just compensation. *See* Williams v. Humphrey, 125 F. Supp. 2d 881, 883, 888 (S.D. Ind. 2000) (concluding that “[i]n effect, Indiana is simply taking the excluded child’s property for the public purpose of helping to finance a public assistance program.”); *see also* Dorothy E. Roberts, *The Only Good Poor Woman: Unconstitutional Conditions and Welfare*, 72 DENV. U. L. REV., 931, 931–32 (1995) [hereinafter *The Only Good Poor Woman*] (discussing property rights and public benefits generally).

83. As some scholars have noted, “it is far from clear that family cap provisions are tools for managing limited resources rather than a punitive measure against poor women who have children.” *Welfare Queens*, *supra* note 69, at 479; *see also* *The Only Good Poor Woman*, *supra* note 82, at 939, 943.

84. *See* Carole M. Hirsch, *When the War on Poverty Became the War on Poor, Pregnant Women: Political Rhetoric, the Unconstitutional Conditions Doctrine, and the Family Cap Restriction*, 8 WM. & MARY J. WOMEN & L. 335, 352 (2002) (“[O]nce the government chooses to provide a benefit, it may not force the recipient to surrender a constitutional right to receive it.”); *see also* *Welfare Queens*, *supra* note 69, at 499–500 (concluding the unconstitutional conditions doctrine is appropriately applied to welfare family caps since the State conditions receipt of a government benefit upon compliance with that condition).

85. *See* Andrew C. McCarthy, *The Prohibition on Abortion Counseling and Referral in Federally-Funded Family Planning Clinics*, 77 CAL. L. REV. 1181, 1188–90 (1999).

86. The Supreme Court first recognized the unconstitutional conditions doctrine in 1926 in *Frost & Frost Trucking Company v. Railroad Commission of California*, in which it held: “If the state may compel the surrender of one constitutional right as a condition of its favor, it may, in like manner, compel a surrender of all. It is inconceivable that guaranties embedded in the Constitution of the United States may thus be manipulated out of existence.” 271 U.S. 583, 594 (1926) (holding that the railroad commission cannot require certain actions by the trucking company merely because it is required to obtain a permit). In more recent years the Court expanded on this principle, explaining that while the government is not obligated to provide the public with a certain benefit, conferral of said benefit may not be conditioned on the sacrifice of one’s constitutional rights. *See, e.g.*, *Liquormart, Inc. v. Rhode Island*, 517 U.S. 484, 488 (1996) (striking down two Rhode Island statutes that prohibited advertisement of alcohol prices as abridging speech under the First Amendment).

tion has been inconsistent,⁸⁸ a recent case⁸⁹ applying the condition to attempts to defund Planned Parenthood has helped to revive the doctrine in the context of reproductive health, rights and justice. This recent application of the doctrine suggests it is ripe for fresh thinking on how the doctrine could be used to challenge family caps.⁹⁰

87. See, e.g., *Maier v. Roe*, 432 U.S. 464, 480 (1977) (upholding denial of funding for abortions); *Wyman v. James*, 400 U.S. 309, 318–25 (1971) (upholding regulation which conditioned AFDC benefits on recipient's permitting a search of their home); *Dandridge v. Williams*, 397 U.S. 471, 485 (1970) (upholding maximum amount of cash aid available to families of certain size); *Shapiro v. Thompson*, 394 U.S. 618, 627 (1969) (invalidating denial of welfare benefits to residents who had lived in state for less than a year); *Sherbert v. Verner*, 374 U.S. 398, 410 (1963) (invalidating a denial of unemployment benefits to some who could not work on Saturday for religious reasons); *Speiser v. Randall*, 357 U.S. 513, 528–29 (1958) (invalidating a state requirement that veterans take a loyalty oath as condition of receiving a veterans' property tax exemption); see also Kate Huddleston, Note, *Border Checkpoints and Substantive Due Process: Abortion Rights in the Border Zone*, 125 YALE L. J. 1744, 1776–80 (2016).

88. While a complete analysis of this inconsistency is beyond the scope of this paper, to understand more about the inconsistency of the use and application of the doctrine, the differing results of five Supreme Court cases involving possible non-exercise of constitutionally protected rights in exchange for government assistance are notable. See *Maier*, 432 U.S. 464 (upholding a condition on the receipt of public health insurance finding that the challenged regulation did not “impinge upon” the constitutional right recognized in *Roe*, even though such medical coverage would be available for a continuing pregnancy); *Wyman*, 400 U.S. 309 (concluding the State did not circumvent the Fourth Amendment by conditioning the receipt of welfare benefits upon the “voluntary” waiver of one's right to be free from government searches); *Dandridge*, 397 U.S. 471 (concluding a welfare family cap does not unconstitutionally interfere with the right to procreate even though a family would not be eligible for additional public benefits for any new children born); *Shapiro*, 394 U.S. 618 (concluding a state law requiring immigrants to be residents of such state for one year before being eligible for welfare was a penalty levied on the constitutional right to travel since it will pressure an individual's decision to exercise that right); *Sherbert*, 374 U.S. 398, 404 (invalidating restrictions on unemployment compensation that denied benefits to an applicant who refused to work for religious reasons on Saturdays because the “governmental imposition of such a choice [denying unemployment benefits to those who exercise their freedom of religion] puts the same kind of burden upon the free exercise of religion as would a fine imposed against appellant for her Saturday worship.”). Each presents a classic unconstitutional-conditions scenario; however, the outcomes and reasoning differ significantly from case to case.

89. *Planned Parenthood of Ind. v. Comm'r of Ind. State Dep't of Health*, 699 F.3d 962, 988 (7th Cir. 2012).

90. A federal district court recently applied the unconstitutional conditions doctrine in a case involving the “defunding” of a reproductive health care clinic. *Planned Parenthood of Greater Ohio v. Hodges*, No. 1:16-cv-539, 2016 WL 4264341, at *5–*11, 2016 U.S. Dist. LEXIS 106985, at *6–*29 (S.D. Ohio Aug. 12, 2016). The court rejected defendants' reliance on *Planned Parenthood of Indiana v. Commissioner of Indiana State Department of Health*, 699 F.3d 962, 988 (7th Cir. 2012) (upholding an Indiana law prohibiting abortion providers from receiving state-administered federal funds by concluding that the law did not “unduly burden a woman's right to obtain an abortion”), finding that the undue burden analysis was improper in a “case about money:”

For constitutional purposes, a federal subsidy program is fundamentally different from ‘direct state interference’ with a particular activity . . . Subsidy conditions, absent special circumstances, ‘cannot be subject to the least—or less-restrictive means mode of analysis—which, unlike the undue burden test . . . , is more appropriate for assessing the government's direct regulation of a federal right—when the government creates a federal spending program.’

Hodges, 2016 WL 4264341, at *10, 2016 U.S. Dist. LEXIS 106985, at *28 (quoting *Alliance for Open Soc'y Int'l, Inc. v. U.S. Agency for Int'l Dev.*, 651 F.3d 218, 243 (2d Cir. 2011)) (internal citations

i. Baker's Cost-Based Test. Professor Lynn Baker has articulated a two-prong test to assist application of the unconditional conditions doctrine in public-assistance cases.⁹¹ The first prong asks whether the condition involves a constitutionally protected activity. If so, the second prong asks whether the condition causes a recipient of public assistance to pay a higher price for participation in a protected activity than would a similarly situated person who did not rely on public assistance.⁹² If it does exact a higher toll from public benefits recipients, then it conditions receipt of benefits unconstitutionally.

The first prong of Baker's test—whether constitutional rights are at stake—applies in the context of welfare family caps because the legislative purpose⁹³ of these laws is to lower the birth rate among cash aid recipients, implicating the constitutionally protected fundamental right to procreate. The Supreme Court first recognized the right to procreate in *Skinner v. Oklahoma*, calling it “a sensitive and important area of human rights.”⁹⁴ In *Eisenstadt v. Baird*,⁹⁵ Justice Brennan wrote, “If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”⁹⁶ In *Planned Parenthood v. Casey*, the plurality recognized that “these . . . intimate and personal choices, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment.”⁹⁷ Thus, there is ample evidence of case support for the constitutional right to procreate.

While some argue that family caps do not burden the fundamental right to procreative liberty because the pregnant person is physically free to carry the pregnancy to term,⁹⁸ the practical effect of capping benefits places an undeniable financial burden on people living in poverty. To deny cash aid to additional

omitted); see also Mary Ziegler, *Sexing Harris: The Law and Politics of the Movement to Defund Planned Parenthood*, 60 *BUFF. L. REV.* 701, 747 (2012).

91. See Lynn Baker, *The Prices of Rights: Toward a Positive Theory of Unconstitutional Conditions*, 75 *CORNELL L. REV.* 1185, 1217 (1990).

92. For an analysis of how this similarly-situated person analysis could be applied to family caps, see generally Steib, *supra* note 67.

93. For a discussion of the purported purpose of these laws, see DOROTHY E. ROBERTS, *KILLING THE BLACK BODY* 202–45 (1997); see also Madina Agénor & Diana Romero, *U.S. Fertility Prevention as Poverty Prevention: An Empirical Question and Social Justice Issue*, 19 *WOMEN'S HEALTH ISSUES* 355, 356 (2009) (suggesting these policies were initially conceived as “mechanism for poverty prevention”); Susan L. Thomas, *Race, Gender, and Welfare Reform: The Antinatalist Response*, 28 *J. BLACK STUD.* 419, 430 (1998) (stating family cap policies were intended to correct the perception of poverty as being caused by “too many newborns” and noting that this misdiagnosis of the causes of poverty has racist and classist undertones).

94. 316 U.S. 535, 541 (1942) (disallowing the state to sterilize people convicted twice or more for crimes of moral turpitude).

95. 405 U.S. 438 (1972) (striking down a Massachusetts statute limiting distribution of contraception only to married couples and not to unmarried people).

96. *Id.* at 453.

97. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992).

98. *C.K. v. Shalala*, 883 F. Supp. 991 (D.N.J. 1995).

children born is “to diminish the support granted to every other child in the family as a new child who lives with her siblings will be supported by the limited income available to the mother.”⁹⁹ The Supreme Court has already acknowledged that family caps cause the existing pie to be divided into smaller and smaller pieces,¹⁰⁰ so it is time for the courts to recognize that a choice between not bearing children and deepening poverty for one’s existing children is no choice at all. Since family caps burden the fundamental right to procreation, the first prong is met.

The second prong asks whether public beneficiaries pay a higher price than do non-beneficiaries to exercise the right at hand. Welfare recipients in states with a family cap pay a much higher price to exercise their fundamental right to procreate than do similarly situated people who do not rely on cash assistance.¹⁰¹ First, they must weigh the painful probability of being pushed further into poverty as a result of having a child excluded from cash aid eligibility.¹⁰² While nearly all parents consider their financial circumstances when deciding whether to have a child, cash aid recipients are operating from a place of deep poverty, so they are concerned not just about their children thriving, they are concerned about them surviving.¹⁰³ Second, cash aid recipients may have to pay the additional dignitary price of engaging in invasive lines of inquiry from welfare officers and social workers about what type of contraception they use and whether the pregnancy resulted from consensual intercourse.¹⁰⁴ People who do not rely on cash assistance are not forced to have these uncomfortable

99. *Welfare Queens*, *supra* note 69, at 505.

100. *See Dandridge v. Williams*, 397 U.S. 471, 477 (1970) (“[A] more realistic view is that the lot of the entire family is diminished because of the presence of additional children without any increase in payments.”).

101. As Albiston and Nielsen note:

Individuals with fewer resources will be pressured to relinquish their liberty interest in bearing children, while those who can afford to spurn government assistance experience no such pressure. Policies penalizing women receiving welfare for bearing children create a constitutional caste in the enjoyment of reproductive liberties: those with the means to remain free from government dependence enjoy greater liberty than those in more meager circumstances.

Welfare Queens, *supra* note 69, at 506–07 (citing Charles Reich, *The New Property*, 73 YALE L. J. 733 (1964)) (internal citations omitted).

102. Welfare family caps increase child poverty by 13.1%. *See* OUT OF ‘CAP’TIVITY, *supra* note 21, at 6 (citing SIGNE-MARY MCKERNAN & CAROLINE RATCLIFFE, URBAN INST., THE EFFECT OF SPECIFIC WELFARE POLICIES ON POVERTY 19 (Apr. 2006), http://webarchive.urban.org/UploadedPDF/411334_welfare_policies.pdf).

103. Some policymakers adopting these policies have suggested it is irrational for people living in deep poverty to have additional children. *See* VETO MESSAGE, *supra* note 84. There are also policymakers and scholars who have argued it is bad for society if policymakers make normative decisions about who is eligible to procreate and that people should make family planning decisions that align with their own beliefs, culture and personal desires. *See Welfare Queens*, *supra* note 69, at 495–97.

104. *See, e.g.,* ARIZ. REV. STAT. ANN. § 46-292(I)(1) (Westlaw through the 2d Reg. Sess. of the 52d Leg. (2016)) (exempting from the family cap babies who were conceived as the result of sexual assault or incest); OUT OF ‘CAP’TIVITY, *supra* note 21, at 13 (noting that California’s exemption for babies conceived due to contraceptive failure only applied to certain methods of permanent or long-acting birth control).

conversations or disclose this kind of highly personal information during pregnancy. As noted above, welfare family caps deprive families of aid required to meet their basic needs, thus deepening their poverty, which can lead to homelessness, hunger, and health problems—hefty prices to pay. Finally, capped families must pay the emotional fine of living in a society that distrusts their decision making,¹⁰⁵ admonishes their parenthood,¹⁰⁶ and devalues their children,¹⁰⁷ as evidenced by the very existence of these population control policies.¹⁰⁸ Such a toll has never been paid by more affluent and privileged parents.

Thus, welfare family caps do not withstand an unconstitutional conditions doctrine analysis under Baker’s cost-based test, because the cost of exercising one’s constitutionally protected procreative right is much greater for a welfare recipient than it is for a non-recipient.

ii. Barksdale’s Harm-Based Analysis. Professor Yvette Barksdale observes that most applications and critiques of the unconstitutional conditions doctrine, particularly the penalty versus nonsubsidy binary version of the doctrine, focus on whether the condition “has prevented, affected, coerced, or pressured the exercise of the constitutional right.”¹⁰⁹ According to Barksdale, this focus is misplaced and ought to shift from whether a benefit condition influences the exercise of a right to whether it punishes the exercise of a right. She says the reason a penalty would be problematic is that it causes harm or suffering, and thus that should be the lens through which conditions are examined.

Barksdale suggests that evaluation should not hinge on whether the condition impedes exercise of a constitutional right, but rather whether the condition imposes harm based on exercise of that right—even if the harm does not

105. See Judith E. Koons, *Motherhood, Marriage, and Morality: The Pro-Marriage Moral Discourse of American Welfare Policy*, 19 WIS. WOMEN’S L.J. 1, 45 (2004) (noting that family caps and other welfare reforms are naked attempts to control the sexuality of women living in poverty because control of women’s reproduction is the cornerstone of patriarchy); see also *Wyman v. James*, 400 U.S. 309, 320 n.8 (1971) (upholding home “visits” to ensure that state funds are being “properly used,” even where such visits were most often not announced in advance and even when the caseworker asks very personal questions in front of children and in front of the recipient’s guests.).

106. See Chris Gottlieb, *Reflections on Judging Mothering*, 39 U. BALT. L. REV. 371, 377 (2010).

107. See PAMELA BRUBAKER, *WELFARE POLICY: FEMINIST CRITIQUES* 39 (Elizabeth M. Bounds et al. eds., 1999) (concluding that deep inequalities are harmful to both persons and society and that those who suffer directly from inequality are devalued in fact and denied conditions necessary for their human dignity as persons. Widespread inequality tears at the social fabric by undermining its moral foundations in the devaluing of those who suffer inequality.).

108. See *Welfare Queens*, *supra* note 69, at 510 (“Indeed, even where the Court has allowed limited burdens on procreative liberty to encourage childbirth, it has made clear that an eugenic objective would not justify similar burdens to prevent childbirth. To the extent that the state’s real interest is an eugenic one in limiting the birth rate in certain disfavored communities, the state interest is not legitimate, let alone compelling enough to support infringing on the fundamental right to procreative liberty.”).

109. Yvette Marie Barksdale, *And the Poor Have Children: A Harm-Based Analysis of Family Caps and the Hollow Procreative Rights of Welfare Beneficiaries Law and Inequality*, 14 LAW & INEQ. 1, 70 (1995).

ultimately prevent its exercise.¹¹⁰ And, if it does cause harm, strict scrutiny should apply—just as it would to a direct attack on the right not obfuscated by the public benefits program.¹¹¹

In the context of welfare family caps, the harm suffered by capped families is destitution—the very thing the public assistance program was designed to combat.¹¹² Caps condition receipt of cash assistance on favored timing of childbearing. Barksdale writes, “The family that makes the disfavored choice is expressly disadvantaged in relation to other similarly situated families that receive higher welfare payments because they chose to bear their children born before they were welfare recipients.”¹¹³

Because welfare family caps burden the fundamental right to procreate, they are presumptively unconstitutional, unless they can be justified by a compelling state interest.¹¹⁴ The interests most commonly proffered¹¹⁵ are saving public funds and ending (‘the cycle of’) poverty, the latter of which is arguably compelling, in theory. However, in practice, welfare family cap policies increase, rather than decrease, poverty among cash aid recipients—an outcome that is manifestly counterproductive to the state’s purported interest. Additionally, while welfare recipients are depicted as having large families, the data does not support this myth—instead families receiving cash aid bear the same number of children, on average, as parents in the general population.¹¹⁶

110. *Id.* at 34, 70.

111. *See id.* at 71.

In such cases, the government harms people not by simply refusing to fund their constitutional right; instead government harms people by refusing to fund their constitutional right *because* of their exercise of the right. Such decisions to allocate government funds on the basis of exercise . . . [this practice] should presumptively be unconstitutional as a direct prohibition, fine, or penalty on the right would be. That is, it should be unconstitutional for government to deny funding expressly on the basis of the exercise of a constitutional right unless the government has a compelling reason for doing so.

Id. at 56.

112. *See id.* at 44 n.145; Orr, *supra* note 82, at 247 (suggesting it is still important to look at the constitutionality of welfare report through family caps because “while the goal of PRWORA was to ‘end welfare as we know it,’ it did not end poverty as we know it.”).

113. Barksdale, *supra* note 09, at 65.

114. *Id.* at 67.

115. *See, e.g., Williams ex. rel. Ricard v. Humphreys*, 125 F. Supp. 2d 881 (S.D. Ind. 2000); *C.K. v Shalala*, 883 F. Supp. 991, 1013 (D.N.J. 1995), *aff’d sub nom. C.K. v. N.J. Dep’t of Health & Human Servs.*, 92 F.3d 171 (3d Cir. 1996); *N.B. v. Sybinski*, 724 N.E.2d 1103, 1110 (Ind. Ct. App. 2000); *Sojourner A. ex rel. Y.A. v. N.J. Dep’t of Human Servs.*, 794 A.2d 822 (N.J. Super. Ct. App. Div. 2002), *aff’d sub nom. Sojourner A. v. N.J. Dep’t of Human Servs.*, 828 A.2d 306 (N.J. 2003).

116. *See* Rebekah J. Smith, *Family Caps in Welfare Reform: Their Coercive Effects and Damaging Consequences*, 29 HARV. J. L. & GENDER 151, 191 (2006). For example, most families participating in CalWORKs, California’s cash assistance program, have one or two children, a figure that is consistent with the birthrate of the state’s general population. *See* CAROLINE DANIELSON, PUB. POLICY INST. OF CAL.,

Even if these policies did successfully further states' interest in ending poverty, they do not rise to the level necessary to pass the next part of Barksdale's evaluation. "The question should be: would the government's asserted interests warrant direct restrictions on procreative rights?" She writes, "If not, then these interests also should not justify a rights-based denial of funding."¹¹⁷ Even in the wake of four decades of repressive restrictions on reproductive rights, it is difficult to fathom a court that would uphold a state's outright prohibition on childbearing/childrearing in the service of a fiscally motivated interest, such as keeping more money in the public purse.

Welfare family caps place unconstitutional conditions on the receipt of cash assistance under Baker's cost-based test and Barksdale's harm-based analysis. Moreover, they disproportionately harm certain marginalized groups in a manner that could also be deemed unconstitutional.

b. Intersectional Disparate Impact Theory. Employment law jurisprudence could lend relevant theories of disparate impact and intersectional discrimination to equal protection claims¹¹⁸ against welfare family caps to more authentically address how they are experienced and to more accurately determine their fairness and defensibility.

Critics commonly point to racist, sexist, and classist motivations undergirding welfare family caps as population control policies aimed at curbing childbearing within undervalued communities considered unfit to reproduce or undeserving of public support for childrearing.¹¹⁹ While these sentiments form the subtext of family caps, the policies do not explicitly target people based on their gender,

CALIFORNIA'S WELFARE RECIPIENTS: FAMILY CIRCUMSTANCES, INCOME, AND TIME ON AID AMONG CALWORKS FAMILIES 11 (2012), http://www.ppic.org/content/pubs/report/R_512CDR.pdf.

117. Barksdale, *supra* note 109, at 67.

118. See Adams & Arons, *supra* note 8, at 51 n.276 ("Thus far, equal protection analysis can proceed only on a claim of disparate treatment, which requires a showing of a purpose or intent to discriminate. Disparate impact theory, which does not require intent, is a form of discrimination analysis sometimes used to determine violations of Title VII of the Civil Rights Act of 1964. To date, the Court has not applied disparate impact theory in an equal protection analysis. The last time the Court visited disparate impact theory under the Equal Protection Clause was in *Washington v. Davis*, where the Court held that a law with racially discriminatory effects—but not purposes—did not violate the Constitution. 426 U.S. 229 (1976). However, the Court has recognized that the discriminatory effects of a policy or practice can be so pervasive as to evince discriminatory purpose. See *Hernandez v. Texas*, 347 U.S. 475 (1954) (holding that the 100% non-selection of Mexican Americans from juries was a violation of the Equal Protection Clause)").

119. See, e.g., ELENA R. GUTIERREZ, POLICING 'PREGNANT PILGRIMS': SITUATING THE STERILIZATION ABUSE OF MEXICAN-ORIGIN WOMEN IN LOS ANGELES COUNTY, in *WOMEN, HEALTH, AND NATION: CANADA AND THE UNITED STATES SINCE 1945* at 379 (Georgina Feldberg et al. eds., 2003); Roberts, *supra* note 93, at 203–08; Risa E. Kaufman, *The Cultural Meaning of the "Welfare Queen": Using State Constitutions to Challenge Child Exclusion Provisions*, 23 N.Y.U. REV. L. & SOC. CHANGE 301, 313 (1997); Eric McBurney, *So Long as Lawmakers Do Not Use the N-Word: The Maximum Family Grant Example of How the Equal Protection Clause Protects Racially Discriminatory Laws*, 14 J. GENDER, RACE & JUST. 497 (2011); Smith, *supra* note 116, at 191.

race, or socio-economic status.¹²⁰ Nevertheless, as disparate impact theory in employment law has established, policies and practices that do not facially discriminate against protected groups can have such a disparate impact on particular groups that they are incontrovertibly discriminatory in their effect.¹²¹

Women of color are disproportionately represented among the millions of Americans struggling economically. This is due, in part, to oppressive structures and customs that limit their participation and acceleration in school and at work while saddling them with caretaking responsibilities. It is also due to pervasive discrimination that plagues their every pursuit. A disproportionate number of families participating in TANF are headed by low-income women of color,¹²² who are, therefore, disproportionately impacted by policies that render their children ineligible for TANF participation.¹²³

Withholding basic needs cash assistance from a family that is already struggling financially tethers them to an anchor in the sea of poverty. The ropes that bind them are made of braided bigotries (e.g., classism, sexism, and racism). Yet, what the courts tend to do is pull out a single strand—the weakest in terms of

120. See generally ARIZ. REV. STAT. ANN. § 46-292(H)(1) (West, Westlaw through 2d Reg. Sess. 52d Leg. (2016)); ARK. CODE R. 208.00.1-2361 (West, Westlaw through Ark. Reg. Vol. XL, No. 7, Jan. 2017); CONN. GEN. STAT. ANN. § 17b-112(d)(2) (West, Westlaw through Gen. Stats. of Conn., Revision of 1958, revised to Jan. 1, 2017); 16 DEL. ADMIN. CODE 5100-3008.2 (West, Westlaw through Del. Reg. of Regulations Vol. 20, Issue 7, Jan. 1, 2017); FLA. ADMIN. CODE R. 65A-4.214 (West, Westlaw through Jan. 23, 2017); GA. COMP. R. & REGS. 290-2-28-.15 (West, Westlaw through Dec. 20, 2016); IDAHO ADMIN. CODE R. 16.03.08.248 (West, Westlaw through amends. in Idaho Admin. Bulletin, Vol. 16-12, Dec. 7, 2016); 470 IND. ADMIN. CODE 10.3-9-2 (West, Westlaw through amends. through Ind. Weekly Collection, Jan. 18, 2017); 106 MASS. CODE REGS. 203.300 (West, Westlaw through Dec. 16, 2016); MISS. CODE ANN. § 43-17-5(1) (West, Westlaw through Jan. 18, 2017); N.J. STAT. ANN. § 44:10-61(a) (West, Westlaw through L.2016, c.83 & J.R. No. 11); N.C. GEN. STAT. ANN. § 108A-27.9 (West, Westlaw through the end of the 2016 Reg. Sess., with the addition of S.L. 2016-126 from the 2016 4th Extra Sess. and through 2017-1 of the 2017 Reg. Sess.) (implemented by N.C. Dep't of Health & Human Servs., Div. of Soc. Servs., Temporary Assistance for Needy Families State Plan P.L. 104-193: The Work First Program, <https://www2.ncdhhs.gov/dss/dcdl/economicfamilyservices/EFS-WF-06-2013a.pdf>); N.D. ADMIN. CODE 75-02-01.2-30.1 (West, Westlaw through Supp. 362 (Oct. 2016)); S.C. CODE ANN. § 43-5-1175 (West, Westlaw through 2016 Sess.); TENN. CODE ANN. § 71-3-104(i) (West Westlaw through 2016 2d Reg. & 2d Extra. Sess. 109th Tenn. Gen. Assemb.); VA. CODE ANN. § 63.2-604 (West, Westlaw through 2016 Reg. Sess.); WIS. STAT. ANN. § 49.19(11s)(b) (West, Westlaw through 2015 Act 392, 4/27/2016); McBurney, *supra* note 119.

121. See generally *Jefferies v. Harris Cmty. Action Ass'n.*, 615 F.2d 1025 (5th Cir. 1980); Kaufman, *supra* note 119, at 313 (noting the interlocking connections between race and poverty); Elaine W. Shoben, *Compound Discrimination: The Interaction of Race and Sex in Employment Discrimination*, 55 NYU L. REV. 793, 803-04 (1980).

122. See OFFICE OF FAMILY ASSISTANCE, U.S. DEP'T. OF HEALTH & HUMAN SERV., CHARACTERISTICS AND FINANCIAL CIRCUMSTANCES OF TANF RECIPIENTS, FISCAL YEAR 2010 (Aug. 8, 2012), <http://www.acf.hhs.gov/ofa/resource/character/fy2010/fy2010-chap10-ys-final> (noting in 2010, 31.9% of TANF families were African-American and 30% were Hispanic and, among adult TANF recipients in 2010, 85.2% were women and 90% were heads of household).

123. See OUT OF 'CAP' TIVITY, *supra* note 21, at 17. In California, which had a family cap from 1995 to 2017, 57-60% of families with a capped child were Latina and 17-24% were African-American. *Id.* at 14 (citing Suzy Chavez Herrera, *California's Minimum Wage Increase Is Not Enough for the Working Poor*, REWIRE (Apr. 25, 2016), <https://rewire.news/article/2016/04/25/californias-minimum-wage-increase-not-enough-working-poor/>).

protection against discrimination—and focus solely on that, in isolation of the others, to determine whether the state has impinged on the equal protection of the law due to them.¹²⁴ In the case of low-income women of color, the court is likely to focus solely on their income level (not a suspect class), as opposed to their race (suspect) and/or gender (quasi-suspect), and thereby avoid applying a form of heightened review to determine whether family cap policies are discriminatory. As a result, low-income women of color, who live under a triple threat of discrimination, are not protected by a suspect classification—much less triply protected by a super-suspect¹²⁵ or compound-suspect classification that acknowledges their unique intersectional position.

It is critical for courts looking at family caps to consider not only the cumulative layers of discrimination experienced by people with intersectional identities, but also to consider how the harm wrought by family cap policies is compounded by other intersecting laws, including abortion funding bans.

B. THE HYDE AMENDMENT

The Hyde Amendment,¹²⁶ named after its author, the now-deceased U.S. Representative Henry Hyde (R-IL), is an appropriations rider that has been passed by Congress every year since 1976 to prohibit federal Medicaid coverage of nearly all abortions. During floor debate over the original amendment, Rep. Hyde made clear his motivations to exploit the political and economic vulnerability of low-income women in order to act on his personal opposition to abortion: “I certainly would like to prevent, if I could legally, anybody having an abortion: a rich woman, a middle-class woman or a poor woman. Unfortunately, the only vehicle available is the . . . Medicaid bill.”¹²⁷ His wish came true: first, as the number of abortions covered by Medicaid plummeted 1,000-fold under the Hyde Amendment, and second, as his model spread to other federal health programs. With only narrow exceptions, abortion is not covered by health insurance programs that serve military personnel, veterans, federal employees, patients of Indian Health Services, people with disabilities who are of childbearing age and dually enrolled in Medicare and Medicaid, residents of Washington, D.C., Peace Corps volunteers, adolescents enrolled in the Children’s Health

124. See Adams & Arons, *supra* note 8, at 53. “However, when a law disproportionately affects women of color—and poor women at that—the Court ignores the disparate racial impact of the law, ‘downgrades’ the standard of review applicable because it discounts the invidiousness of sex-based classifications, and then applies rational review based on their indigent status alone.” *Id.*

125. The concept of super-suspect classification is an articulation of an intersectional class of people, analyzing the classifications in tandem, rather than in a vacuum. See *Harris v. McRae*, 448 U.S. 297, 323 (1980); Elizabeth Jones, *Looking Back to Move Forward: An Intersectional Perspective on McRae*, 1 GEO. J. L. & MOD. CRITICAL RACE PERSP. 379, 381 (2009).

126. The Hyde Amendment, originally enacted by Congress in 1976, prohibits the use of federal Medicaid funds for reimbursing the cost of abortions. Pub. L. 94-439, Title II § 209 (1976); see also *Harris*, 448 U.S. at 302.

127. 123 CONG. REC. 19, 700 (1977) (statement of Rep. Hyde).

Insurance Program, or people incarcerated in federal facilities.¹²⁸

The Hyde Amendment and its progeny maintain and exacerbate a two-tier system of clinic-based abortion access that leaves the right in place for those who possess the resources to exercise it while rendering it nearly meaningless rhetoric for the rest of the population. Rights protected by the Constitution are, by design, supposed to be enjoyed by all—and not just the privileged few.¹²⁹

1. Reflections on Precedent: *Harris v. McRae*

Cora McRae, a pregnant Medicaid enrollee in need of an abortion; the Board of Global Ministries of the United Methodist Church Women's Division and select officers; and a healthcare conglomerate operating hospitals that provided abortion care challenged the Hyde Amendment under the Due Process and Equal Protection clauses of the Fifth Amendment and the Free Exercise Clause of the First Amendment.¹³⁰ But, ultimately in 1980, a sharply divided Supreme Court ruled against the petitioners in *Harris v. McRae*.¹³¹ The five-Justice majority reasoned that while the government may not place a substantial obstacle in the path of a person seeking an abortion, it need not remove an obstacle not of its own creation (i.e., indigence) and it was, therefore, not obligated to subsidize abortion care.¹³² In other words, the majority claimed it was the enrollees' own poverty—and not the lack of Medicaid coverage—that kept Medicaid recipients from being able to afford abortion care. Furthermore, it determined that Medicaid coverage of other pregnancy-related treatments did not unfairly promote or coerce one pregnancy outcome over another through the selective disbursement

128. See Cynthia Soohoo, *Hyde-Care for All: The Expansion of Abortion-Funding Restrictions Under Health Care Reform*, 15 CUNY L. REV. 391, 392 (2013), http://academicworks.cuny.edu/cgi/viewcontent.cgi?article=1023&context=cl_pubs; see also 32 C.F.R. § 199.4(e)(1)–(2) (2014) (restrictions on abortion care in the military); 38 C.F.R. § 17.38(c)(1) (2014) (no abortion care or counseling by the Veterans Administration under any circumstances); U.S. IMMIGRATION & CUSTOMS ENFORCEMENT, PERFORMANCE-BASED NATIONAL DETENTION STANDARDS 2011 at 325 (2011), <https://www.ice.gov/doclib/detention-standards/2011/pbnds2011r2016.pdf> (restrictions on abortion care in detention centers); Adams & Arons, *supra* note 8, at 13; Heather D. Boonstra, *Insurance Coverage of Abortion: Beyond the Exceptions for Life Endangerment, Rape, and Incest*, 16 GUTTMACHER POL'Y REV. 2, 4 (2013), https://www.guttmacher.org/sites/default/files/article_files/gpr160302.pdf.

129. See Jessica Arons, *The Hyde Amendment Hurts Poor Women of Color Most*, NEWSWEEK (Sept. 23, 2016), <http://www.newsweek.com/hyde-amendment-hurts-poor-women-color-most-501763>. Of course, as discussed elsewhere in this article, pregnant people will get abortions no matter what legal impediments are put in their way.

130. See *McRae v. Califano*, 491 F. Supp. 630, 736–42 (E.D.N.Y. 1980).

131. 448 U.S. 297, 326–27 (1980); see also *Webster v. Reprod. Health Servs.*, 492 U.S. 490, 508 (1989).

132. See *Harris*, 448 U.S. at 316–17; *Webster*, 492 U.S. at 509 (analogizing the Hyde Amendment to a Missouri law which prohibited public employees from performing abortions in public hospitals, stating “Just as Congress’ refusal to fund abortions in *McRae* left ‘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,’ Missouri’s refusal to allow public employees to perform abortions in public hospitals leaves a pregnant woman with the same choices as if the State had chosen not to operate any public hospitals at all.”).

of public benefits.¹³³ To reach this conclusion, the majority drew a hair-splitting distinction between “direct state interference with a protected activity” and “state encouragement of an alternative activity.”¹³⁴

The *McRae* majority weighed the obstacles people faced in securing an abortion against the government’s purported interests of advancing fetal life and women’s health, and then upheld the constitutionality of abortion coverage bans.¹³⁵

The *McRae* opinion saddled abortion rights’ jurisprudence with heavy weights that have been dragging abortion coverage—and other abortion access issues—down the ladder of judicial scrutiny ever since. *Roe v. Wade*¹³⁶ declared that the State’s interest in the potential life of the fetus did not outweigh its interest in the pregnant person’s health at any point in gestation and, therefore, laws restricting abortion must have exceptions, such as when the pregnant person’s health is threatened by the pregnancy. Nevertheless, *McRae* upheld a restriction that lacked a health exception.

Moreover, the Court abandoned several of its doctrinal principles, such as government neutrality, by allowing Congress to cover childbirth yet deny abortion coverage with the express intent of discouraging abortion. The Court enabled government coercion by allowing legislators to impose their own biases toward childbirth, in an effort to influence people’s constitutionally protected decisions about whether to carry a pregnancy to term. And the majority of the Court ignored or dismissed the unconstitutional conditions doctrine¹³⁷ by allowing Congress to condition receipt of a public benefit on the relinquishment of a fundamental right by covering the costs of pregnancy-related care only when people forfeited their right to abortion.

2. New Approaches for Future Cases

The *McRae* majority’s treatment of abortion funding bans as separate and somehow more acceptable than other types of restrictions on abortion access has been reified in conventional thinking to the point that it has calcified. Yet, there are many cracks in that foundation. First, the case was decided by a sharply divided court and opposed by four impassioned dissenters. Second, it has been soundly critiqued by scholars, state courts, and advocates for all of the reasons it was wrongly decided. Third, a new generation of legal thinkers has begun to forecast the future of the case’s undoing through novel arguments and nascent theories.

133. *Harris*, 448 U.S. at 315.

134. *Id.*

135. *Id.*

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

137. *See* discussion of the unconstitutional conditions doctrine, *infra* Part II.A.2.a.

Some have posited human rights¹³⁸ and equal protection arguments on which *McRae* could be overturned. For example, people seeking abortions could qualify as a protected class under several theories—from having suffered a history of invidious discrimination,¹³⁹ to being the target of government animus,¹⁴⁰ to experiencing the disparate impacts of the Hyde Amendment as a result of living at the intersection of race, gender, and class subordination.¹⁴¹

To add to these concepts, this section will highlight two additional approaches that may be possible avenues for a *McRae* reversal: first, whether withholding abortion coverage denies pregnant people living in poverty “equal dignity” as articulated by the court in *Obergefell v. Hodges*; and second, whether the State is constitutionally obligated to provide funding for abortion, just as it is required to provide legal assistance to defend against criminal charges.

a. Equal Dignity. The Court’s equal protection rulings in the abortion coverage context have been based on its holdings that a) economically disadvantaged people do not constitute a suspect class, and that b) the state therefore need not show a compelling interest in order to refuse to cover most abortions with Medicaid funds.¹⁴² Because the federal government, and many states, have withheld abortion coverage for people at various income levels¹⁴³—refusing to pay for anyone’s abortions¹⁴⁴—low-income people have thus far been unable to successfully advance an equal protection claim based on the argument that these

138. The human rights in question include life, health, dignity, and equality. See Adams & Arons, *supra* note 8, at 53. See generally Soohoo & Stolz, *supra* note 4.

139. See Adams & Arons, *supra* note 8, at 58; see also Laura Sjoberg, *Where Are the Grounds for the Legality of Abortion? A 13th Amendment Argument*, 17 CARDOZO J.L. & GENDER 527, 541 (2011) (suggesting that the basis for abortion rights are best framed in the Thirteenth Amendment contexts because, “[m]ore imagined than real in life, sex equality in law tends to be more formal or hypothetical than substantive and delivered”).

140. See Adams & Arons, *supra* note 8, at 46.

141. See *id.* at 140; see also Crenshaw, *supra* note 5, at 1242–44 (discussing how the intersectionality theory operates).

142. Because the legal challenge in *Roe* was a facial challenge, not an “as applied” challenge, the Court did not have an opportunity to balance the interests of specific parties in the case. See *Gonzales v. Carhart*, 550 U.S. 124, 167 (2007) (noting that *Roe*, *Casey*, and *Stenberg* were all facial challenges). The use of a facial challenge did not require the Court to look at the particular impacts to particular women or classes of people—including poor and low-income people—who may have been impacted differently by the law. While this is positive in some ways, since the Court did not need to do a case-by-case inquiry for pre-viability abortions, or inquire as to whether a particular condition has or is likely to occur in which the procedure prohibited will be used, it also means the Court in *Roe* did not have reason to look at how the government may fail to ensure access to a fundamental right for people living in poverty. While the Court could have engaged in such inquiries had it wanted to, it did not do so.

143. The Hyde Amendment has been over-interpreted and extended beyond Medicaid, to also apply in a variety of other contexts, including insurance for military personnel, federal employees, Indian Health Services, as well as private insurance in the states. Soohoo, *supra* note 128.

144. Professor Kenji Yoshino describes this government approach of refusing to provide any benefit as a way to avoid an Equal Protection challenge as “level[ing] down,” which is described in more detail *infra* Part II.B.2.a.ii. See also Kenji Yoshino, *A New Birth of Freedom?: Obergefell v. Hodges*, 129 HARV. L. REV. 147, 173 (2015).

policies discriminate on the basis of income. Additionally, due process claims have been unsuccessful because the “liberty protected by the Due Process Clause . . . does not confer an entitlement to such funds as may be necessary to realize all the advantages of that freedom.”¹⁴⁵

Fortunately, the Supreme Court’s decision in *Obergefell v. Hodges*¹⁴⁶ provides new grounds for taking the best of both Equal Protection and Due Process claims to give further heft to the liberty right created in *Roe*.¹⁴⁷ The Court in *Obergefell* articulated a concept of “equal dignity,”¹⁴⁸ that can elide the unnecessary distinctions between negative and positive rights, or due process and equal protection theories. Justice Kennedy writes: “The fundamental liberties protected by the Fourteenth Amendment’s Due Process Clause extend to certain personal choices central to individual dignity and autonomy, including intimate choices defining personal identity and belief.”¹⁴⁹ Some have suggested *Obergefell*’s equal dignity is a contemporary articulation of a human rights frame.¹⁵⁰ Under such an interpretation, if *Roe* stands for the right to be free from government intrusion into decisions about procreation, then *Obergefell*’s articulation of equal dignity requires people have the government resources to effectuate that right.¹⁵¹

i. Due Process and Equal Protection Combined. In *Obergefell*, the Court identified a fundamental and arguably positive right to marry by considering the impact of the denial of such rights on people who wish to marry someone of the same sex. This analysis, as demonstrated below, could be imported to the abortion context.¹⁵² *Obergefell* expresses a vision of due process and equal

145. *Harris v. McRae*, 448 U.S. 297, 317–18 (1980).

146. *Obergefell v. Hodges*, 135 S. Ct. 2584, 2585 (2015).

147. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 857 (1992) (citing *Roe v. Wade*, 410 U.S. 113, 153 (1973)) (“The *Roe* Court itself placed its holding in . . . the liberty relating to intimate relationships, the family, and decisions about whether or not to beget or bear a child.”).

148. Justice Kennedy’s opinion in *Obergefell* traces the concept of equal dignity from the Due Process Clause of the Fourteenth Amendment, to the abandonment of the law of coverture, to the first equal protection cases challenging sex-based classifications as denying the equal dignity of men and women. *Obergefell*, 135 S. Ct. at 2595, 2603.

149. *Id.* at 2589.

150. See, e.g., Laurence H. Tribe, *Equal Dignity: Speaking Its Name*, 129 HARV L. REV. F. 16, 20 (2015), <http://harvardlawreview.org/2015/11/equal-dignity-speaking-its-name/>. See generally MICHAEL ROSEN, *DIGNITY: ITS HISTORY AND MEANING* (2012), for more on the constitutional underpinnings of such a dignity analysis. See also REBECCA J. COOK ET AL., *REPRODUCTIVE HEALTH AND HUMAN RIGHTS* (2003); Lance Gable, *Reproductive Health as a Human Right*, 60 CAS. W. RES. L. REV. 957 (2010) (discussing the application of a human rights frame to reproductive health rights and justice).

151. It is not clear whether the equal dignity interest at issue in *Obergefell* is the right to be free from government interference in the bedroom or the right to be recognized by the government through marriage. We believe it is ripe for scholars to argue that *Lawrence* stands for the negative right (the right to be free from government interference in the bedroom) and *Obergefell* stands for the positive right (to be recognized by the government).

152. For some time, scholars and advocates have argued against using the fundamental rights approach because they believe that the right to privacy framework is limiting—since the right to privacy is a negative right that does not require government to take any action to ensure the right. This opposition stems from the negative and positive right distinction, and those who are against the right to privacy

protection as intertwined.¹⁵³ Justice Kennedy explains for the majority in *Obergefell* that the Fourteenth Amendment's guarantees of liberty and equal protection are two sides of the same coin, both integral to ensuring to all the full promise of liberty and "equal dignity in the eyes of the law."¹⁵⁴ He goes on to say,

Rights implicit in liberty and rights secured by equal protection may rest on different precepts and are not always co-extensive, yet in some instances each may be instructive as to the meaning and reach of the other . . . This interrelation of the two principles furthers our understanding of what freedom is and must become.¹⁵⁵

The government has failed to adequately protect the liberty right created in *Roe* because it has done nothing to ensure access to abortion for people living in poverty—denying equal dignity to people who cannot afford to pay for an abortion out-of-pocket.

Professor Kenji Yoshino argues that this intertwined view of due process and equal protection, which he refers to as "antissubordination liberty," substantially alters substantive due process jurisprudence.¹⁵⁶ By emphasizing the antissubordi-

structure argue for an approach that obligates the government to ensure abortion rights are accessible. As Professor Yoshino has said, while the Court has previously implied a greater willingness to "protect negative 'freedom from' rights rather than positive 'freedom to' rights," he asserts that the decision has now been displaced by *Obergefell*. Yoshino, *supra* note 144, at 150.

153. See *Obergefell*, 135 S. Ct. at 2602–03 ("The Due Process Clause and the Equal Protection Clause are connected in a profound way, though they set forth independent principles . . . The interrelation of the two principles furthers our understanding of what freedom is and must become."). It should be noted that Linda Greenhouse, Reva Siegel, and other scholars had previously suggested that *Casey* requires states to act "consistent with the dignity of women" or they will be acting in a way that denies women "liberty and equality." Linda Greenhouse & Reva B. Siegel, *Casey and the Clinic Closings: When "Protecting Health" Obstructs Choice*, 125 YALE L.J. 1428, 1439, 1441 (2016) [hereinafter *Casey and the Clinic Closings*]. They have also suggested that the Due Process and Equal Protection Clauses should work in tandem. See, e.g., *M.L.B. v. S.L.J.*, 519 U.S. 102, 120–21 (1996) (employing a fusion of Equal Protection and Due Process to analyze the denial of payment for a transcript needed in an appeal of a loss of parental rights); Reva B. Siegel, *Dignity and the Politics of Protection: Abortion Restrictions Under Casey/Carhart*, 117 YALE L.J. 1694, 1792 (2008) ("Gender paternalism . . . denies women the very forms of dignity that *Casey*—and the modern equal protection cases—protect"); Neil S. Siegel & Reva B. Siegel, *Equality Arguments for Abortion Rights*, 60 UCLA L. REV. DISC. 160, 164–65 (2013) ("The Court has also invoked equality concerns to make sense of the Due Process Clauses in the area of abortion rights . . . This emphasis on the role autonomy of the pregnant woman reflects the influence of the equal protection sex discrimination cases, which prohibit the government from enforcing stereotypical roles on women.").

154. *Obergefell*, 135 S. Ct. at 2608.

155. *Id.* at 2603.

156. See Yoshino, *supra* note 144, at 174. Anti-subordination principles have also been invoked in the abortion context. As Jack Balkin observes, "a long history of commentators has argued that abortion rights are secured by constitutional guarantees of sex equality premised on some version of an antissubordination principle." Jack M. Balkin, *Abortion and Original Meaning*, 24 YALE FAC. SCHOLARSHIP SERIES 291, 292 (2007). Balkin argues that the antissubordination view of the abortion right has deep roots in the original meaning of the Fourteenth Amendment. *Id.* But see Jennifer Hendricks, *Body and Soul: Equality, Pregnancy, and the Unitary Right to Abortion*, 45 HARV. C.R.-C.L. L. REV. 329, 330–331

nation component of due process,¹⁵⁷ *Obergefell* provides a new way for thinking about fundamental rights and liberty. “One of the major inputs into any such [substantive due process] analysis will be the impact of granting or denying such liberties to historically subordinated groups.”¹⁵⁸ In other words, *Obergefell* considers the impact of a law on a vulnerable group when deciding whether an alleged right should be recognized in the first place.

ii. *Obergefell’s* Helix. Since *Obergefell*, an intertwined due process and equal protection claim exists in the formulation of “equal dignity.”¹⁵⁹ In *Equal Dignity: Speaking Its Name*, Professor Laurence Tribe argues that this tightly wound “helix” of due process and equal protection results in the creation of a notion of “equal dignity” in the eyes of the law.¹⁶⁰ Post-*Obergefell*, “a government practice that limits options available to members of a particular group need not have been deliberately designed to harm the excluded group if its oppressive and unjustified effects have become clear in light of current experience and understanding.”¹⁶¹ Through this analysis, Kennedy concluded that same-sex couples must be allowed to marry.

By urging us to consider the discriminatory effects of government practices on particular groups, Kennedy’s articulation of “equal dignity” provides a new way to challenge Medicaid abortion coverage bans, which can effectively deny one in four Medicaid-eligible people¹⁶² their fundamental right to make personal decisions relating “to family relationships, procreation, and childrearing.”¹⁶³

Yoshino notes that a standard equal protection ruling in *Obergefell* would have permitted states either to “level up by granting both same-sex couples and opposite-sex couples marriage licenses or to level down by refusing to grant licenses to both sets of couples.”¹⁶⁴ If states refuse to issue marriage licenses

(2010) (critiquing Balkin’s antisubordination equality-based view of the abortion right as two distinct rights—the right not to be forced by the state to bear children, and the right not to be forced by the state to become a parent). Hendricks argues “this division between the body and social suggests that women’s liberty can be protected only by breaking it into pieces that have analogs in men’s experiences.” *Id.* She proposes building a liberty framework based in women’s experiences. *Id.* Further dialogue is necessary in order to consider whether Hendricks’s view of a liberty-based framework is compatible with Yoshino’s antisubordination liberty.

157. Yoshino suggests that Justice Kennedy deliberately bases his ruling in liberty and due process rather than equal protection, in order to protect true equality interests. Yoshino, *supra* note 144, at 173.

158. *Id.* at 174.

159. See generally Tribe, *supra* note 150. It should be noted that Linda Greenhouse and Reva Siegel promised a reading of *Casey* that requires states to act “consistent with the dignity of women” or they will be acting in a way that denies women “liberty and equality.” *Casey and the Clinic Closings*, *supra* note 153, at 1441.

160. Tribe, *supra* note 150, at 17.

161. *Id.* at 19.

162. See STANLEY K. HENSHAW ET AL., GUTTMACHER INST., RESTRICTIONS ON MEDICAID FUNDING FOR ABORTIONS: A LITERATURE REVIEW 18 (2009), <http://www.guttmacher.org/pubs/MedicaidLitReview.pdf>.

163. *Obergefell v. Hodges*, 135 S. Ct. 2584, 2599 (2015) (citing *Lawrence v. Texas*, 539 U.S. 2472 (2003)).

164. Yoshino, *supra* note 144, at 173.

across the board (rather than issue them to same-sex couples), Yoshino argues this action by the State would “not violate an equal protection ruling,” but it would “violate a due process ruling.”¹⁶⁵ As a result, Justice Kennedy’s vision of due process is not only giving legal thinkers a new way of thinking about fundamental rights and liberty, but also a new way of thinking about equality—one that is true equality, not just formal equality.¹⁶⁶

Obergefell invites theorists to look at the effect of government policies impacting fundamental rights on particular groups, even groups that the Court has not treated with solicitude in the past, such as low-income women of color.¹⁶⁷ Demonstrating the historical subordination¹⁶⁸ of this group would be crucial to the analysis. Though abortion coverage bans are facially-neutral, “current experience and understanding” demonstrate that they disproportionately deny poor women of color a fundamental right.¹⁶⁹ This group of women, therefore, may be able to argue that their right to “equal dignity,” or equal access to a fundamental right, has been violated. Though historically such a group would have had to demonstrate purposeful discrimination¹⁷⁰ to advance this sort of “disparate treatment” claim, with *Obergefell*, the Court has signaled a shift away from its earlier focus on intentional discrimination,¹⁷¹ and so a particular marginalized group may have a stronger challenge to a facially-neutral law.

Thus, if the government interferes with an indigent woman’s abortion decision by covering all pregnancy-related care except abortion, it might offend equal protection principles by subordinating women living in poverty (who disproportionately belong to minority racial or ethnic groups) and depriving them of the dignity of procreational autonomy. This is true even if the laws were not expressly intended to discriminate based on sex, race, or class at the time they were passed. *Obergefell* does not require a showing that all of the state laws

165. *Id.* (noting that Kennedy expanded our thinking of equality by basing its ruling on the Due Process Clause (this time in addition to, rather than in lieu of, the Equal Protection Clause)).

166. *See id.*

167. Other scholars have suggested low-income women may also be an appropriate group to show historical subordination. *See, e.g.,* Alyssa Engstrom, Note, *The Hyde Amendment: Perpetuating Injustice And Discrimination After Thirty-Nine Years*, 25 S. CAL. INTERDISC. L.J. 451, 451–52 (2016).

168. *See* Adams & Arons, *supra* note 8, at 51 (applying *Carolene Products* elements for suspect classification to Medicaid abortions, including history of discrimination, political powerlessness, and animus).

169. It should be noted Justice Marshall’s dissent in *McRae* made it clear he thought such discrimination was intended. *See* Harris v. McRae, 448 U.S. 297, 344 (1980) (writing that the Hyde Amendment “is designed to deprive poor and minority women of the constitutional right to choose abortion.”). Others looking at such a theory might explore recent data proving Justice Marshall was correct. *See generally, e.g.,* SEPARATE AND UNEQUAL, *supra* note 62; WHOSE CHOICE, *supra* note 35 (showing a shift in how governments in other countries have approached public funding for abortion, making the U.S. a stark outlier in its approach to public funding for abortion).

170. The congressional record for the Hyde Amendment may provide evidence of purposeful discrimination against low-income people. *See supra* note 127 and accompanying text.

171. Of course, this does not signal a shift away from allowing action against intentional discrimination, only that proof of intentional discrimination is not required.

defining marriage in terms of opposite-sex couples were passed because of malice or irrational prejudice against gays and lesbians. Instead, it simply states that whatever their motivations,¹⁷² the laws produced had the effect of demeaning and subordinating people who want to marry someone of the same sex.¹⁷³

Though *Obergefell* obscures the typical tiered scrutiny approach to equal protection, its focus on the effects of facially neutral government policies on marginalized groups may support a redefinition of the class of people affected by Medicaid coverage bans as a super-suspect class. Racism and discrimination are at the heart of social and economic inequality. A claim could establish that the Hyde Amendment “falls particularly hard on women of color.”¹⁷⁴ Women¹⁷⁵ of color are disproportionately likely to be insured by the Medicaid program,¹⁷⁶ and are therefore more likely to lack coverage for abortion. As such, to the extent a tiered scrutiny approach to equal protection would be relevant to an “equal dignity” claim,¹⁷⁷ the Court should apply heightened scrut-

172. It is worth noting these laws facially treated same-sex couples differently than heterosexual couples, and had the purpose of doing so.

173. See *Obergefell v. Hodges*, 135 S. Ct. 2584, 2602 (2015).

174. Boonstra, *supra* note 12, at 49 (discussing why people of color may have higher rates of abortion); see also Jones, *supra* note 125, at 380 (arguing disparate impact and suspect classification together as an argument for Equal Protection and heightened scrutiny); Melissa Gilliam, *Health-Care Inequality Is Key In Abortion Rates*, REWIRE (Aug. 13, 2008, 7:00 AM), <https://rewire.news/article/2008/08/13/health-care-inequality-key-abortion-rate-disparities/> (pointing out that African Americans have suffered a “long history of discrimination, lack of access to high-quality, affordable health care; too few educational and professional opportunities; unequal access to safe, clean neighborhoods; and, for some African Americans, a lingering mistrust of the medical community.”). See generally HENRY J. KAISER FAMILY FOUND. ET AL., PUTTING WOMEN’S HEALTH CARE DISPARITIES ON THE MAP: EXAMINING RACIAL AND ETHNIC DISPARITIES AT THE STATE LEVEL (2009), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7886.pdf>; Christine Dehlendorf et al., *Disparities in Family Planning*, 202 AM. J. OBSTETRICS & GYNECOLOGY 214 (2010). In addition, a higher percentage of black women lack access to contraceptives, which statistically leads to higher rates of unintended pregnancy. See Susan A. Cohen, *Abortion and Women of Color: The Bigger Picture*, 11 GUTTMACHER POL’Y REV. 2, 3 (2008), https://www.guttmacher.org/sites/default/files/article_files/gpr110302.pdf.

175. Sex discrimination jurisprudence typically uses the term women, so we will use that term here. We note, however, that abortion is not a “women’s issue,” and is instead an issue that impacts all people with the capacity to become pregnant. We believe sex discrimination legal theory in the context of abortion should be reframed to include anyone with the capacity to become pregnant, including transmale individuals.

176. See Boonstra, *supra* note 12, at 49 (“Thirty percent of black women and 24% of Hispanic women aged 15–44 are enrolled in Medicaid, compared with 14% of white women”—even though they represent 12.7%, 17.1% and 61.7% of the total number of women, respectively (citing U.S. Census Bureau, Table 10—Projections of the Population by Sex, Hispanic Origin, and Race for the United States: 2015 to 2060, Population Projections (2014)).

177. We understand *Obergefell* to mean the class of people harmed is relevant only to identify whether the class of affected people has historically been subordinated, not whether the class is “suspect.” However, to the extent courts applying this equal dignity principle were to still require a tiered analysis, we encourage scholars to explore how abortion coverage bans must be analyzed using a heightened level of review because the *McRae* Court’s view that these bans harm people based on income alone is incorrect—instead race and gender must be incorporated into the analysis. See e.g., Adams & Arons, *supra* 8, at 173.

iny¹⁷⁸ when reviewing abortion coverage bans. *Obergefell*, as analyzed by Professors Yoshino and Tribe, can be explored and expounded upon in the reproductive rights context to discredit the State's guise of abortion coverage bans to effectively deny low-income people their fundamental right to equal dignity regarding procreation, family relationships, and child-rearing.

b. Constitutional Obligation. The court's opinion in *McRae*¹⁷⁹ is inconsistent with the Court's jurisprudence on other constitutionally protected activities. Around the same time the Supreme Court decided it was the woman's own poverty, not the lack of Medicaid coverage, that kept her from being able to afford abortion care, the Supreme Court also created an affirmative obligation for the government to provide constitutionally protected government funding for the assistance of legal counsel through its criminal defendants' rights jurisprudence.¹⁸⁰

There is lacking that equality demanded by the Fourteenth Amendment where the rich man, who appeals as of right, enjoys the benefit of counsel's examination into the record, research of the law, and marshalling of arguments on his behalf, while the indigent, already burdened by a preliminary determination that his case is without merit, is forced to shift for himself. The indigent, where the record is unclear or the errors are hidden, has only the right to a meaningless ritual, while the rich man has a meaningful appeal.¹⁸¹

While on the one hand, the Supreme Court's rulings in four seminal cases on public support for legal counsel¹⁸² "held that the government, both federal and state, was constitutionally required to ensure that those rights were protected at the state's expense, regardless of its having played no part in creating the accused's poverty,"¹⁸³ the *McRae* Court instead concluded that indigent women still have the ability to "enjoy the full range of constitutionally protected freedom of choice, [financial constraints] are the product not of governmental restrictions on access to abortions, but rather of her indigency."¹⁸⁴ The Court has also refused

178. Strict scrutiny is appropriate, rather than some other heightened level of scrutiny or an undue burdens analysis, since abortion coverage bans burden a fundamental right, and, therefore, operate as a deprivation of liberty and equal dignity. However, as discussed in note 177, any higher level of review is better than rational basis.

179. *Harris v. McRae*, 448 U.S. 297, 326–27 (1980).

180. See, e.g., Kenneth Agran, *When Government Must Pay: Compensating Rights and the Constitution*, 22 CONST. COMMENT 97, 100 (2005); Lauren Maisel Goldsmith, *Redefining Viability: Why the State Must Ensure Viable Alternatives to Pregnancy and Motherhood*, 20 CARDOZO J.L. & GENDER 579, 580 (2014).

181. *Douglas v. California*, 372 U.S. 353, 357–58 (1963).

182. See generally *Douglas*, 372 U.S. 353; *Gideon v. Wainwright*, 372 U.S. 335 (1963); *Griffin v. Illinois*, 351 U.S. 12 (1956); *Powell v. Alabama*, 287 U.S. 45 (1932).

183. Goldsmith, *supra* note 180, at 593 (citing *Douglas*, 372 U.S. 353; *Gideon*, 372 U.S. 335; *Griffin*, 351 U.S. 12; *Powell*, 287 U.S. 45).

184. *Harris*, 448 U.S. at 316.

to let poverty be a barrier to access to justice in the family law context, when the court held where parental rights are at stake, a person's poverty cannot be what stands in the way of appellate review.¹⁸⁵

Although the Courts have refused to analyze the impact of poverty on the exercise of a constitutionally protected right to a free trial and the right to access abortion in the same way, the theory behind these two situations are analogous. For example in *Gideon*, the State did not place any barriers that would have prevented a criminal defendant from hiring an attorney and theoretically, using the *McRae* reasoning, the defendant could “enjoy the full range of constitutionally protected” assistance of counsel and the defendant's indigency was the only obstacle to decent legal representation.¹⁸⁶ But, instead of using the *McRae* rationale, the *Gideon* Court nevertheless required the state to pay for effective representation, because an attorney is the only “buffer against the enormous resources and coercive power of the state helping to ensure a fair trial while preserving the independence and integrity of his decision-making process.”¹⁸⁷

Gideon provides a useful analogy for low-income people who cannot afford abortion care without support from the State.¹⁸⁸ The clear anti-abortion rhetoric behind abortion coverage bans¹⁸⁹ demonstrates a need for a similar buffer to enable a pregnant person to withstand the “enormous resources and coercive power of the state” and reach an informed and intelligent decision free from financial pressure or other forms of government pressure.¹⁹⁰ Such coercive pressure is clear not only from the legislative history of Hyde, but from a myriad

185. See *M.L.B. v. S.L.J.*, 519 U.S. 102, 120–21 (1996).

186. *Id.*

187. Agran, *supra* note 180, at 128.

188. It is worth noting the rhetoric around a government-subsidized attorney outlined in *Gideon* may not match the reality of securing effective assistance of counsel. See, e.g., David, Rudosvky, *Gideon and The Effective Assistance of Counsel: The Rhetoric and the Reality*, 32 LAW & INEQ. 371, 371–73 (2014). Of course, similar criticisms have been made about the rhetoric of Medicaid coverage not always matching the reality.

189. Because Congress has passed the Hyde Amendment each year since 1976 as part of the annual appropriations process, there is plenty of evidence of the coercive intent behind the legislative votes. See Adams & Arons, *supra* note 8, at 10. In 1976, Rep. Henry Hyde (R-IL) said during the floor debate, “I would certainly like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle class woman, or a poor woman. Unfortunately, the only vehicle available is the [] Medicaid bill. A life is a life.” CAROL EMMENS, *THE ABORTION CONTROVERSY* 67 (1987). In 1977, one legislator described the purpose of abortion coverage ban as preventing “the slaughter of innocent, inconvenient unborn children.” FREDERICK S. JAFFE ET AL., *ABORTION POLITICS: PRIVATE MORALITY AND PUBLIC POLICY* 129 (1981). Other legislative history suggests a person shouldn't be able to just wake up “with a hangnail to be able to get an abortion.” *Id.* at 130. Even then-President Carter defended Hyde by saying “As you know there are many things in life that are not fair, that wealthy people can afford and poor people can't.” *Id.* at 132. Justice Thurgood Marshall also noted the intent behind the Hyde amendment was “to deprive poor and minority women of the constitutional right to choose abortion.” *Harris*, 448 U.S. at 344 (Marshall, J., dissenting).

190. See Agran, *supra* note 180, at 128. (“Government's efforts to influence the people's decision to have an abortion is not only hostile to the right, but is coercive in a manner analogous to the adversarial role of government that triggered compensating obligations in cases such as *Gideon*, *Douglas*, *Streater*, and *M.L.B.*”).

of other abortion restrictions that are clearly intended to dissuade people from having an abortion at all.¹⁹¹

C. SELF-INDUCED ABORTION

Mounting legal restrictions, financial obstacles, and clinic closures, leave an untold number of people without access to clinical abortion care every year. “For women in large swaths of the United States, access to abortion services is more limited now than at any time since *Roe v. Wade*.”¹⁹² When someone needs to end a pregnancy, practical barriers and cultural preferences may make clinic-based care unattainable, untenable, or undesirable.

The very idea that a pregnant person’s actions or inactions resulting in pregnancy loss can constitute a crime is inherently problematic, but state laws and government actors criminalize people who end their own pregnancies.¹⁹³ Such prosecutions are often based upon “antiquated”¹⁹⁴ laws motivated by sexism,¹⁹⁵ classism, and racism.¹⁹⁶

191. See generally *Casey and the Clinic Closings*, *supra* note 153.

192. Rowan, *supra* note 63, at 70.

193. See *McCormack v. Herzog*, 788 F.3d 1017, 1022 (9th Cir. 2015) (“McCormack admitted to the police that she self-induced an abortion after ingesting a pack of five pills.”).

194. Molly Redden, *Tennessee Woman Jailed for Attempting Abortion Accepts Plea Deal for Release*, *GUARDIAN* (Jan. 11, 2017, 12:46 P.M.), <https://www.theguardian.com/world/2017/jan/11/tennessee-woman-released-abortion-attempt-tennessee> (“The charges against her call attention to antiquated, unconstitutional laws that pose a threat to anyone who might seek an abortion or lose a pregnancy,” said Farah Diaz-Tello, SIA legal team senior counsel.).

195. The first laws to regulate abortion did punish people for inducing abortions. See LESLIE J. REAGAN, *WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE, AND LAW IN THE UNITED STATES* 10 (1997) (citing JAMES C. MOHR, *ABORTION IN AMERICA* 20–25 (1978)); Cyril C. Means Jr., *The Law of New York Concerning Abortion and the Status of the Foetus, 1664-1968: A Case of Cessation of Constitutionality*, 14 N.Y.L.F. 411, 426 (1968); Cyril C. Means, Jr., *The Phoenix of Abortional Freedom: Is a Penumbral or Ninth-Amendment Right about to Arise from the Nineteenth Century Legislative Ashes of a Fourteenth-Century Common-Law Liberty?*, 17 N.Y.L.F. 335, 337 (1971); see also *Hatfield v. Gano*, 15 Iowa 177, 178 (Iowa 1863). “The criminalization of abortion, however, is a more recent phenomenon, dating back to the 19th century, and supported by patriarchal social norms linked to female domesticity and motherhood, and a desire to control female sexuality.” Francine Coeytaux & Leila Hessini, *In Our Own Hands: What U.S. Women Can Learn from Self-Use of Medication Abortion Worldwide*, *REWIRE* (Nov. 7, 2013, 7:56 P.M.), <https://rewire.news/article/2013/11/07/in-our-own-hands-what-u-s-women-can-learn-from-self-use-of-medication-abortion-worldwide/>. Criminal abortion laws, however, granted “medical men” sole discretion as to whether a pregnant person would be granted an abortion. See HORATIO R. STORER & FRANKLIN FISKE HEARD, *CRIMINAL ABORTION: ITS NATURE, ITS EVIDENCE, AND ITS LAW* 4 (1868) (“[M]edical men are the physical guardians of women and their offspring; from their position and peculiar knowledge necessitated in all obstetric matters to regulate public sentiment, and to govern the tribunals of justice”).

196. Criminal abortion statutes were adopted in response to gender, racial, and class anxieties. “The visible use of abortion by middle-class married women, in conjunction with other challenges to gender norms and changes in the social makeup of the nation, generated anxieties among American men of the same class. Hostility to immigrants, Catholics, and people of color fueled this campaign to criminalize abortion.” Reagan, *supra* note 195, at 138. Additionally, race and class largely impacted the quality of the abortion experience. For example, during the 1930s, low-income women and black women relied upon self-induced methods of abortion at higher rates than more affluent women. Reagan, *supra* note 195, at 138.

In addition to criminal prosecutions for abortion, a number of other laws needlessly stand in the way of self-directed access to abortion and interfere with not only a person's right to abortion under *Roe*, but also invade the home as a place to experience private reproductive experiences.¹⁹⁷ Even though people in the U.S. have a long tradition of ending their own pregnancies¹⁹⁸ and it is

Self-induced abortions caused more complications and hospitalization than did those induced by physicians or midwives. Since poor women and black women were more likely to try to self-induce abortions and less likely to go to doctors or midwives, they suffered more complications. Dr. Regine K. Stix learned from interviewing almost a thousand women in 1931 and 1932 that self-induced abortions, as compared to midwife- or physician-induced abortions, had the highest rates of infection and hemorrhage. Women reported having no complications after their abortions in 91 percent of the abortions performed by doctors and 86 percent of those performed by midwives. In contrast, only 24 percent of the self-induced abortions were without complications.

Id.

197. By 1900, nearly every state but Kentucky had prohibited abortion at all stages of pregnancy. Mohr, *supra* note 195, at 229. Some have suggested it was not the laws criminalizing abortion that made self-induced abortion less common, but instead an 1873 anti-obscenity law, called the Comstock Law, which prevented the dissemination of abortion and birth control information through the federal mail system to both physicians and the public. *Id.* at 252; *see also* Reagan, *supra* note 195, at 88. When newspapers stopped advertising where to acquire abortion-inducing herbs and pills, it took away the ability to easily acquire medications required to end a pregnancy. This is not to say people stopped having self-induced abortions. Even toward the end of the 19th century when abortion was outlawed in most states, pregnant people continued to induce their own abortions, relying mainly on herbal methods and drugs obtained from pharmacists. *Id.*

198. *See, e.g.*, ANGUS McLAREN, REPRODUCTIVE RITUALS: THE PERCEPTION OF FERTILITY IN ENGLAND FROM THE SIXTEENTH CENTURY TO THE NINETEENTH CENTURY 103–05 (1984); Mohr, *supra* note 195, at 58–66; Reagan, *supra* note 195, at 9 (“This age-old idea underpinned the practice of abortion in America. The legal acceptance of induced miscarriages before quickening tacitly assumed that women had a basic right to bodily integrity.”); JULIA C. SPRUILL, WOMEN’S LIFE AND WORK IN THE SOUTHERN COLONIES 325–26 (1938). Colonial home medical guides gave recipes for ‘bringing on the menses’ with herbs that could be grown in one’s garden or easily found in the woods. Reagan, *supra* note 195, at 9. In 1860, abortion before quickening (which occurs around 16–21 weeks) was legal in all but three of the thirty-three states. At the time, abortion was provided or attended by homeopaths, herbalists, midwives, empirics, and druggists, including by herbs and tinctures ordered through the mail. The most famous practitioner, Madame Restell, openly provided abortion services for thirty-five years from her offices in New York, Boston, and Philadelphia—she even hired traveling salespeople to tout a “Female Monthly Pills.” In addition to the practices of early white Americans, these practices were also common among Africans brought to America as slaves. *See* JOHN M. RIDDLE, EVE’S HERBS: A HISTORY OF CONTRACEPTION AND ABORTION IN THE WEST 2–3 (1999); Rebecca L. Vaughan, *Oppression Breeds Rebellion: Herbal Contraceptives and Abortifacients and The Role They Fulfilled in Allowing African American Women to Maintain their Reproductive Autonomy During Slavery* (Dec. 1, 1997) (unpublished thesis, Clark Atlanta University) (on file with ETD Collection for AUC Robert W. Woodruff Library, Clark Atlanta University). It is also clear curanderas and Native American herbal healers provided a number of herbal remedies for contraception and abortion. *See generally* 5 ALEXANDER VON HUMBOLDT & AIME BONPLAND, PERSONAL NARRATIVE OF TRAVELS TO THE EQUINOCTIAL REGIONS OF THE NEW CONTINENT, DURING THE YEARS 1799-1804 at 28–32 (Helen Maria Williams trans., 2d ed. 1827); THOMAS JEFFERSON, NOTES ON THE STATE OF VIRGINIA 58 (Thomas Abernethy ed., Harper & Row 1964) (1832) (reporting that Native Americans “had learned the practice of procuring abortion by the use of some vegetable”); Londa Schiebinger, *Lost Knowledge, Bodies of Ignorance, and the Poverty of Taxonomy as Illustrated by the Curious Fate of Flos Pavyonis, an Abortifacient*, in PICTURING SCIENCE, PRODUCING ART (Peter Galison & Caroline A. Jones eds., 1st ed. 1998). Additionally, African healers likely learned about local flora from

common for pregnant people in the U.S. and around the world to use medication to self-induce abortions,¹⁹⁹ there have been unwarranted legal implications for those who provide, possess, or ingest abortion medication, as well as those who relay information about it or provide care to people before, during, or after taking medication to end a pregnancy without a prescription.²⁰⁰ A recent challenge to the criminalization of self-induced abortion provides both a foundation and fodder for further-reaching challenges that strike down problematic statutes and establish constitutional protections for people who end their own pregnancies and those who assist them.

1. Reflections on Precedent: *McCormack v. Hiedeman*

After being arrested and charged for violating Idaho law, which makes it a felony for “any woman to undergo an abortion in a manner not authorized by statute,” Jennie Linn McCormack challenged this and other statutes under the federal constitution.²⁰¹ In 2012, in *McCormack v. Hiedeman*, the Ninth Circuit struck down the state’s 1972 criminal abortion law, as an undue burden on the abortion right.²⁰² In reaching its conclusion, the court explained that abortion statutes were never intended to punish people²⁰³ who obtain abortions and that patients are not required to police their providers to ensure their compliance with the laws.²⁰⁴

Native American healers, as such these two groups often used similar practices, such that it may be difficult to identify the true source of some herbal abortion practices. Ely VanDeWalker, *The Detection of Criminal Abortion and Study of Foeticidal Drugs*, Boston, 1872, in *ABORTION IN NINETEENTH CENTURY AMERICA: SEX, MARRIAGE AND SOCIETY* 40 (1974).

199. See *Bold Action*, *supra* note 53, at 610.

200. See *ADAMS & MIKESSELL*, *supra* note 63, at 6.

201. *McCormack v. Hiedeman*, 694 F.3d 1004 (9th. Cir. 2012). Jennie Linn McCormack was a pregnant, unemployed mother of three who ingested unspecified abortion pills her sister ordered for her from an internet physician to end her own pregnancy. *McCormack v. Herzog*, 788 F.3d 1017, 1022 n.3 (9th. Cir. 2015). McCormack decided to buy medication from an online physician because there were no licensed abortion providers in all eight southeastern counties of Idaho near where she lived. *Hiedeman*, 694 F.3d at 1008. McCormack would have been required to drive more than 100 miles to the closest abortion clinic. *Id.* at 1008 n.1. Prosecutors in Idaho charged McCormack with a violation of a physician-only abortion statute, subjecting her to arrest and jail. *Id.* at 1008. In August 2011, the U.S. District Court for the District of Idaho granted a temporary restraining order enjoining McCormack’s prosecution under the 1972 law but denied a request for an injunction against the twenty-week ban because McCormack was not being prosecuted under it. *McCormack v. Hiedeman*, 2011 WL 4436548, *5, *8, 2011 U.S. Dist. LEXIS 107823 (D. Idaho Sept. 23, 2011); *Hiedeman* 694 F.3d at 1025. In September 2012, the Ninth Circuit Court of Appeals largely affirmed the lower court’s injunction. *Id.* Through a subsequent lawsuit brought by McCormack, the Ninth Circuit overturned the state’s 20-week abortion ban, as well as the state’s requirement of hospitalization for second trimester abortions, and the state’s requirement that first trimester abortions take place in a “properly staffed” facility by a physician who has made “satisfactory arrangements” with a hospital overturned in a related case. *Herzog*, 788 F.3d at 1030–1033.

202. *Hiedeman*, 694 F.3d at 1025.

203. *Id.* at 1018.

204. See *id.* at 1015.

While the Supreme Court has permitted many restrictions that make obtaining an abortion more difficult, particularly for low-income women, it has not authorized the criminal prosecution of women seeking abortion care. Imposing criminal liability upon women for their providers' purported failure to comply with state abortion regulations places a substantial obstacle in the path of women seeking an abortion.²⁰⁵

The circuit court explained that requiring pregnant people to “police” their abortion providers constituted an undue burden.²⁰⁶ However, this analysis assumes the person ending their own pregnancy is doing so with the assistance of an abortion provider,²⁰⁷ which is not always the case. The circuit court noted several times that the medications the plaintiff in *Hiedeman* took to induce her own abortion were prescribed by a physician,²⁰⁸ whereas many herbs and medications used for self-induced abortion are not.²⁰⁹

Should similar statutes be challenged in other states, courts ought to follow the persuasive logic of the Ninth Circuit and refuse to authorize the criminal prosecution of people seeking abortion care. And, they ought to extend the logic beyond the physician involvement in the *Hiedeman* case to clarify that abortion restrictions are not to be used to prosecute people who end their own pregnancies when physicians are not involved.

205. *Id.* at 1018 (internal citations omitted).

206. *See id.* at 1015. Physician-only abortion statutes may impose criminal liability on anyone other than a licensed physician from performing abortions. As the court noted in *McCormack v. Heideman*, even post-*Roe*, most modern state criminal statutes continue to apply criminal liability to third parties who perform abortion in a manner not prescribed by the statute. *Id.* at 1011. Many of these statutes expressly exempt the pregnant person from liability for obtaining an abortion—and do not hold them liable for actions or inactions that affect their pregnancy outcomes. Some pre-*Roe* state courts have interpreted these physician-only abortion laws and concluded they do not apply to pregnant persons—even in states where the statutes do not expressly exempt pregnant persons. *See, e.g.*, *Heath v. State*, 459 S.W.2d 420, 422 (Ark. 1970); *Hillman v. State*, 503 S.E.2d 610, 611 (Ga. Ct. App. 1998); *Basoff v. State*, 119 A.2d 917, 923 (Md. 1956); *State v. Pearce*, 57 N.W. 652, 653 (Minn. 1894); *State v. Barnett*, 437 P.2d 821, 822 (Or. 1968). The Supreme Court has not clarified that a physician-only abortion law could not be applied to the pregnant person.

207. Although the *Hiedeman* Court noted that McCormack relied upon a physician, the facts of the case make clear that McCormack used pills her sister ordered for her from an internet physician. *McCormack v. Herzog*, 788 F.3d 1017, 1022 n.3 (9th Cir. 2015). The practice of securing pills from physicians through telemedicine with providers based in another place is a practice that is common around the world. Coeytaux & Hessini, *supra* note 195. As such, this case could potentially have broader application to also include pills secured for self-use.

208. *See Hiedeman*, 694 F.3d at 1008, 1013, 1015, 1018–19.

209. There is some limited social science research on how and where pregnant people acquire abortion pills, which suggests the pills may be acquired over-the-counter in countries where no prescription is required and on the Internet. *See, e.g.*, Erik Eckholm, *A Pill Available in Mexico Is a Texas Option for Abortion*, N.Y. TIMES (July 13, 2013), <http://www.nytimes.com/2013/07/14/us/in-mexican-pill-a-texas-option-for-an-abortion.html>.

2. New Approaches for Future Cases

Despite the fact that the courts have generally sided with people who end their own pregnancies,²¹⁰ prosecutors are wont to overreach, sometimes misusing laws related to assault, homicide, and drugs not expressly intended for application to self-induced abortion.²¹¹ This section discusses some new approaches for scholars and the legal community to build off the existing undue burdens jurisprudence in the context of self-induced abortion, explores new Fourth Amendment terrain to better protect those who end their own pregnancies, and revisits the original articulation of the abortion right to provide better protections for people who end their own pregnancies. In all of these sections we explore not only how the constitution can be used to halt the criminalization of abortion, but also how it can be used to better protect those who end their own pregnancies.

a. Cumulative Burdens. In applying the undue burden standard, modeled by *Casey*,²¹² courts typically examine whether a single restriction by itself places a substantial obstacle in the path of a person choosing to end a pregnancy.²¹³ However, by looking at individual abortion restrictions in fabricated isolation from one another, courts are blinded to the rest of the impediments scattered along the veritable obstacle course a pregnant person must conquer in order to obtain clinic-based abortion care.²¹⁴ While estimations of the impediment imposed by an individual abortion restriction may not rise to the level of being

210. See, e.g., *Hiedeman*, 694 F.3d 1004; see also *Patel v. State*, 60 N.E.3d 1041 (Ind. Ct. App. 2016); *State v. Ashley*, 701 So. 2d 338, 341–42 (Fla. 1997).

211. See, e.g., *Patel*, 60 N.E. 3d at 1055–62; see also *Montour County Court of Common Pleas, Court Summary Whalen, Jennifer A.* (2017); *Lexington County Eleventh Judicial Circuit Public Index, South Carolina v. Flores* (2013). Gabriella Flores, an undocumented immigrant and mother of three children living in South Carolina, took misoprostol pills to end her own pregnancy. But, this experience was shrouded with fear of facing jail time and separation from her children, and she put off seeking medical care as a result. She was convicted of performing an illegal abortion and sentenced to ninety days in jail. *Id.*

212. See Caitlin E. Borgmann, *Winter Count: Taking Stock of Abortion Rights After Casey and Carhart*, 31 *FORDHAM URB. L. J.* 675, 688 (2003) (“But the manner in which the Justices administered the undue burden test in *Casey* highlights an additional, critical problem: the test’s indifference to the cumulative burdens that multiple restrictions impose. The joint opinion addressed the challenged provisions *seriatim*, applying the undue burden standard to each. It examined how onerous each restriction was as if no other restrictions existed, ignoring how a woman would fare under the mounting obstacles as the Court upheld restriction upon restriction. Thus, under *Casey*, a single provision may not place a substantial obstacle in a woman’s path to abortion. A state can, and many do, accomplish the same result, however, by erecting separate hurdles that cumulatively amount to what is surely a ‘substantial’ obstacle for many women.”).

213. See, e.g., *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 879 (1992); *Planned Parenthood Ass’n of Kan. City, Mo. v. Ashcroft*, 462 U.S. 476, 481–82 (1983); *Planned Parenthood of Cent. Mo. V. Danforth*, 428 U.S. 52, 62–63 (1976); *Planned Parenthood of Greater Tex. Surgical Health Serv. v. Abbott*, 748 F.3d 583, 590, 600 (5th Cir. 2014); see also *Gonzales v. Carhart*, 550 U.S. 124, 124–25 (2007); *Ayotte v. Planned Parenthood of Ne. New Eng.*, 546 U.S. 320, 323–24 (2006); *Stenberg v. Carhart*, 530 U.S. 914, 921 (2000); *Planned Parenthood Sw. Ohio Region v. DeWine*, 696 F.3d 490, 493–94 (6th Cir. 2012).

214. See *Kotting & Ely*, *supra* note 31.

substantial, when considered in combination with the litany of other abortion restrictions, the cumulative burden is far more likely to be seen as undue. By considering the cumulative burdens and effects as experienced by someone seeking abortion care, courts would issue more accurate and just rulings.²¹⁵

In recent years, advocates and lawyers alike had become almost accustomed to an undue burden rubric that ignored the entire obstacle course a person must run to secure an abortion. Recent opinions,²¹⁶ however, offer some hope that certain judges are willing to climb down from the theoretical ether to witness and acknowledge the real-life hardships and practical impacts of decades of abortion restrictions allowed to proliferate. Furthermore, there are indications of a nascent cumulative burdens analysis by the Supreme Court in *Whole Woman's Health*²¹⁷ and by the Ninth Circuit in *Hiedeman*.²¹⁸ Professors Reva Siegel and Linda Greenhouse predict that the Supreme Court post-*Whole Women's Health* will “consider[] restrictions cumulatively and in context, describ[e] how, taken as a whole, they will alter the lived conditions of exercising the abortion right.”²¹⁹ The Ninth Circuit in *Hiedeman* was careful to point out part of the reason pregnant people may self-induce abortion is because state legislatures have adopted cumulative restrictions that both erect barriers that limit access to clinic-based abortion care and stigmatize those seeking abortions.²²⁰

In addition to cumulative burdens, courts may also look at the cumulative effects of these laws on those who end their own pregnancy, or who are accused of doing so. It is not only the compound interaction of abortion restrictions that

215. See Benjamin A. Hooper, *The Negative Effects of Cumulative Abortion Regulations: Why the 5th Circuit Was Wrong in Upholding Regulations on Medication Abortions* (Planned Parenthood of Greater Texas Surgical Health Services v. Abbott), 83 U. CIN. L. REV. 1489, 1509 (2016), <http://scholarship.law.uc.edu/uclr/vol83/iss4/12> (“Taking a lenient approach to these regulations has resulted in a buildup of cumulative regulations that have resulted in the closures of more and more clinics and have placed a substantial obstacle in the path of women who seek abortion procedures. A better method for determining the constitutionality of new abortion regulations would not only consider the burden that results from the specific piece of legislation in question, but also the cumulative effect that other abortion regulations within the state also have on a woman’s ability to seek out an abortion.”).

216. See, e.g., *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016); *McCormack v. Herzog*, 788 F.3d 1017 (9th Cir. 2015); *Planned Parenthood Ariz. v. Humble*, 753 F.3d 905, 915–16 (9th Cir. 2014); *McCormack v. Hiedeman*, 694 F.3d 1004, 1017 (9th Cir. 2012); *Planned Parenthood of Wis. v. Van Hollen*, 94 F. Supp. 3d 949, 989–93 (W.D. Wis. 2015); *Whole Women's Health v. Lakey*, 46 F. Supp. 3d 673, 681–83 (W.D. Tex. 2014), *vacated by Whole Woman's Health v. Hellerstedt*, 833 F.3d 565 (5th Cir. 2016); *Planned Parenthood Se. v. Strange*, 9 F. Supp. 3d 1272, 1295–96 (M.D. Ala. 2014).

217. 136 S. Ct. 2292 (2016).

218. 694 F.3d 1004, 1017 (9th Cir. 2012).

219. Linda Greenhouse & Reva B. Siegel, *The Difference a Whole Woman Makes: Protection for the Abortion Right After Whole Woman's Health*, 126 YALE L.J. F. 149, 162 (2016) (referencing *Whole Woman's Health*, 136 S. Ct. at 2313); see also *Whole Woman's Health*, 136 S. Ct. at 2321 (Ginsburg, J., concurring) (suggesting legislatures “strew impediments to abortion”). Legislatures who do this force people to go out in search for providers who are often in remote cities, counties, and states.

220. See *Hiedeman*, 694 F.3d at 1016 (noting that the Idaho statute heaps yet another substantial obstacle in the already overburdened path people face when deciding whether to obtain an abortion, noting not only the cost of the abortion as a barrier, but also the requirement to travel long distances, and to put up with anti-abortion protesters).

determine a person's ability to exercise the constitutionally protected right to end a pregnancy. A multitude of identities, conditions, institutions, and structures also factor in. Laws and policies relating to reproduction affect people differently, depending on a host of demographic, economic, and geographic factors. Throughout the nation's history, people of color, immigrants, and welfare recipients—particularly those with the capacity to become pregnant—have been targeted by harsh government-enforced moral regimes controlling or coercing their reproductive and parental decision-making.²²¹ State regulation of reproduction intersects on a daily basis with other legal systems and regimes, such as immigration, public benefits, and criminal justice.

In the context of self-induced abortion, it is especially important to consider the interplay of regulation, discrimination, and exposure likely to ensnare disproportionate numbers of people from vulnerable communities in the criminal justice system. Because low-income individuals, on average, participate in more public programs than wealthier individuals, they must also interact more with government agencies (e.g., social workers, welfare offices, public health officials) and be subjected to more observation and evaluation.²²² Public assistance recipients may be required to undergo drug-testing,²²³ interviews to determine eligibility,²²⁴ or mandatory home visits.²²⁵

The heightened interaction with authorities and corresponding inspection into every aspect of the lives of low-income individuals mean that their pregnancies are also easily subject to surveillance. Wealthier people who have abortions, miscarriages, or stillbirths can buffer themselves from observation or judgment, such as by having physicians or midwives tend to them at home or in a private

221. For example, an immigrant may not be able to make a truly volitional decision about when to have a child if she is excluded from health insurance programs that cover contraception. A formerly incarcerated person who was forcibly sterilized while in prison may not be able to parent because they lack access to assisted reproductive technologies. A pregnant transgender person may not birth a child the way they want because they lack access to gender-inclusive or respectful birthing options. A same-sex couple or unmarried individual may not become parents at all because of barriers they face to adoption. A parent may not be involved in their child's life in a meaningful way because they are locked behind bars. A parent graduating from cash assistance may not be able to secure a job because they do not have access to quality, affordable childcare. Sometimes these cumulative impacts of the law will harm the same person in more than one way.

222. See generally Wendy Bach, *The Hyperregulatory State: Women, Race, Poverty, and Support*, 25 YALE J. L. & FEMINISM 317 (2013).

223. See, e.g., *Drug Testing for Welfare Recipients and Public Assistance*, NAT'L CONF. OF ST. LEGS. (Mar. 28, 2016), <http://www.ncsl.org/research/human-services/drug-testing-and-public-assistance.aspx> (listing states with legislation requiring drug testing of public assistance recipients).

224. See, e.g., STACY DEAN, CTR. ON BUDGET & POLICY PRIORITIES, SNAP: COMBATING FRAUD AND IMPROVING PROGRAM INTEGRITY WITHOUT WEAKENING SUCCESS, TESTIMONY OF STACY DEAN, VICE PRESIDENT FOR FOOD ASSISTANCE POLICY, BEFORE THE SUBCOMM. ON GOV'T OPERATIONS & THE INTERIOR OF THE COMM. ON OVERSIGHT AND GOV'T REFORM, U.S. H.R. (June 9, 2016), <https://oversight.house.gov/wp-content/uploads/2016/06/2016-06-09-Stacy-Dean-Testimony-CBPP.pdf> (noting that all applicants for SNAP must be interviewed before receiving benefits).

225. See, e.g., NAT'L CONF. OF ST. LEGIS., HOME VISITING ENACTED LEGISLATION IN STATES (2017) http://www.ncsl.org/documents/cyf/HV_Enacted_08_16.pdf.

clinic. They may also benefit from cultural perceptions of wealthier people as more responsible parents, casting aside potential doubts about their intentions, actions, or inactions resulting in the loss. By contrast, low-income people may experience pregnancy loss and abortion in a more “public” arena, given proximity to neighbors in multiple-family housing units, the prevalence of police in their neighborhoods, and regular interactions with government agents, who may notice the flatness of a previously pregnant belly and report their suspicions.

Racial bias and over-policing in communities of color may increase the likelihood of arrest for pregnant people of color. Studies have shown that pregnant people of color are more frequently targeted for arrests and other deprivations of liberty. For instance, in a trend that is evident throughout the nation, between 1973 and 2005, approximately 15% of Florida’s population was African-American, but 75% of its pregnancy-related criminal cases were brought against African Americans, while only 22% were brought against Caucasians who represented 60% of the overall population.²²⁶ It is reasonable to expect that since more people of color are arrested for pregnancy-related reasons generally, more pregnant people of color will be arrested for pregnancy loss that is suspected to be self-induced abortion.

Hyper-regulation of abortion, intrusion into the lives of low-income individuals, and over-policing of communities of color combine to form cumulative burdens that are relevant to analyzing any attempt to criminalize self-induced abortion.

b. Fourth Amendment Protections. As legal thinkers explore new ways to challenge laws that either criminalize self-induced abortion or regulate self-administered abortifacients or abortion pills, some are examining how such laws are “incongruous with the legally cognizable importance of the home in both common law and constitutional law.”²²⁷ Because many self-induced abortions happen in the home, the holding in *Griswold v. Connecticut* can be a starting point to develop a legal theory that protects the privacy interest involved in abortion at home because such a theory would engage both aspects of traditional privacy case law: “the physical boundaries of the home”²²⁸ as a protected space against governmental surveillance and intrusions by third parties as well as “the

226. See Paltrow & Flavin, *supra* note 55, at 311.

227. Yvonne Lindgren, *The Doctor Requirement: Griswold, Privacy, and At-Home Reproductive Care*, 32 CONST. COMMENT. (forthcoming 2017).

228. The Supreme Court in *Griswold v. Connecticut* identified the right of privacy as a right related to sexual and reproductive decision-making that occurs within the privacy of the home. When someone ends a pregnancy at home, it raises the specter of increased governmental surveillance in the home—which was a matter of concern for the *Griswold* court—since the government may search for “telltales signs” of use of abortion medication. While the abortion medication most commonly used, misoprostol, is undetectable unless clinicians find undissolved pills in or on the pregnant person, the police may use internet searches that may reveal the names of the websites where the pills were obtained or may look through the person’s garbage. See *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965); see also GYNUITY HEALTH PROJECTS, CLAIMS OF DETECTION OF MISOPROSTOL IN WOMEN ACCUSED OF INDUCED

deeply personal activities that occur within the home.”²²⁹

The courts have recognized the home as a legally cognizable physical space and provide additional protections for the intimate personal experiences of the lives lived within the home and as a place of personal autonomy and dignity.²³⁰ Both common law and constitutional law provide enhanced protections within the home. Common law notions of privacy protect the home as “a location of solitude and repose and are often conceptualized as the “right to be let alone.”²³¹

Constitutional privacy law protects the home as a location free of governmental surveillance and intrusion. Further, the Court has recognized the right of privacy to encompass more than merely spatial privacy within the physical confines of the home. Rather, the Court has held that the privacy right encompasses deeply personal decisions related to marriage, child rearing, reproduction and intimacy.²³²

Experiencing abortion at home is the confluence of *Griswold*'s tenets: privacy, intimate association, and reproduction. “The guarantee of privacy of intimate experiences that take place within the home is at the very heart of *Griswold*.”²³³ Any law that seeks to limit abortion at home or to prosecute people for abortions at home usurps pregnant people's liberty and autonomy.

At a time when lawmakers are forcing people²³⁴ to travel often hundreds of miles for an abortion,²³⁵ it is even more important to preserve the home as a place for experiencing abortion in private. “There's another, perhaps more insidious, aspect of burdensome travel that's even harder to quantify. It's a type of social exclusion through which women, however temporarily, are effectively banished from society.”²³⁶ Instead, the law needs to allow people the opportunity to experience abortion on their own terms—with their choice of location, companion, and method.

ABORTION 1 (2013), http://www.womenonwaves.org/bn/media/inline/2014/4/9/claims_of_misoprostol_in_blood_1.pdf.

229. Lindgren, *supra* note 227.

230. *See Griswold*, 381 U.S. at 484–85 (relying on Fourth Amendment and Fifth Amendment government intrusion cases such as *Boyd v. United States*, 116 U.S. 616 (1886) and *Mapp v. Ohio*, 367 U.S. 643 (1961)); *see also* Louis Henkin, *Privacy and Autonomy*, 74 COLUM. L. REV. 1410, 1424–25 (1974).

231. Lindgren, *supra* note 227 (citing Samuel D. Warren & Louis D. Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193, 195 (1890) (arguing for the recognition in law of the right of privacy which they described as the “right to be let alone.”)).

232. *Id.*

233. *Id.*

234. *See generally Casey and the Clinic Closings*, *supra* note 153.

235. *See Jones & Jerman*, *supra* note 38, at 706–13; Keller & Yarrow, *supra* note 38; *see also* Gayle Binion, *Reproductive Freedom and the Constitution: The Limits on Choice*, 4 BERKELEY WOMEN'S L.J. 12, 12–41 (1988).

236. Elisa L. Slattery, *The Hidden Consequences of Forcing Women to Travel for Abortions*, OPEN SOC'Y FOUND. (July 7, 2016), <https://www.opensocietyfoundations.org/voices/hidden-consequences-forcing-women-travel-abortion>.

A pregnant person may prefer to have an abortion in the privacy and comfort of their own home, rather than in the more public setting of a hospital or clinic.²³⁷ They may want to be surrounded by a spouse, family, or friends—rather than strangers. Additionally, they may want to self-medicate using abortion pills, vitamins, or herbs,²³⁸ because they view these methods as more natural or less physically invasive than surgical abortion.²³⁹ “Rather than a place of sanctuary, solitude, and repose, the home is becoming a place of increasing regulation of people’s reproductive lives.”²⁴⁰ *Griswold’s* right to privacy provides a basis for challenging laws limiting access to home-based abortion care.

c. Robust Right to Choose. It is not enough to simply end the criminalization of self-induced abortion. A robust reading of the right to choose to have an abortion would include a person’s choices of method,²⁴¹ means, companion, and location,²⁴² as being well within the *Roe* framework and requiring judicial protections from political interference. Evidence for this notion lies in the historical framework of the *Roe* decision,²⁴³ the historical regulation of the

237. *Self-Induction of Abortion*, *supra* note 47, at 142.

238. There is a wide range of people finding herbal information online, in books, or from trusted herbalists with experience. Herbs continue to be the only or preferred option for many specific populations, including people who usually use herbs and alternative medicine, immigrants with specific connections to herbs, herbal healers, and others. We cannot assume all abortion methods are equal, but at the same time, we do not want to demonize herbal abortion, because this will only further stigmatize an abortion experience that is preferred by many. See Molly Dutton-Kenny, *The Midwife as Abortion Provider Part 1: Home Abortion Options and Skilled Attendance*, SQUAT BIRTH J. 1, 3 (2013), <http://static1.squarespace.com/static/559a971ee4b02838d134f030t/5625a192e4b063ee06129145/1445306770427/SQUAT1eng.pdf>.

239. *Id.*

240. Lindgren, *supra* note 227.

241. See Jennifer Hendricks, *Body and Soul: Equality, Pregnancy, and the Unitary Right to Abortion*, 45 HARV. C.R.-C.L. L. REV. 329, 368 (2010) (discussing the pregnant person’s right to choose the method of abortion).

242. See Lindgren, *supra* note 227; see also Megan Wainwright et al., *Self-Management of Medical Abortion: A Qualitative Evidence Synthesis*, 24 REPROD. HEALTH MATTERS 155, 162 (2016) (finding most pregnant people “desire to be able to choose the method of abortion that fit their context,” and that “having the choice to self-administer medication at home [versus having it in clinic] may be an important element of acceptability of medica[tion] abortion for women.”).

243. Although couched in terms of undue burdens and “[de]spite the many encroachments on *Roe* over the years, its central tenet still stands—the right to decide to have an abortion is fundamental.” Adams & Arons, *supra* note 8, at 30; see also Michael Dorf, *Symposium: Abortion Is Still a Fundamental Right*, SCOTUSBLOG (Jan. 4, 2016, 11:28 A.M.), <http://www.scotusblog.com/2016/01/symposium-abortion-is-still-a-fundamental-right/>. Some have suggested that self-induced abortion is not a fundamental right because it is not “deeply rooted in American history and tradition.” Suzanne M. Alford, Note, *Is Self-Abortion a Fundamental Right?*, 52 DUKE L. J. 1011, 1029 (2003). We believe this question deserves fresh legal thinking because herbal abortion has been a primary form of abortion for millennia. Self-administered herbs and medications to end a pregnancy or cause a miscarriage have deep historical roots and deserve a greater understanding. See Cornelia Hughes Dayton, *Taking the Trade: Abortion and Gender Relations in an Eighteenth-Century New England Village*, 48 WM. & MARY Q. 19, 24 (1991) (“Perhaps only a few New Englanders knew how to prepare an abortifacient or knew of books that would give them recipes, but many more, especially young women who lived with the fear of becoming pregnant before marriage, were familiar with at least the idea of taking an abortifacient.”). The first laws

practice of self-induced abortion, and the safety and efficacy of self-directed abortion care. Because the circumstances of an abortion—like all health procedures—matters, people must be allowed to align their health care with their values. Requiring abortions be performed by doctors or in abortion clinics²⁴⁴ coerces some people's health care decisions and forces them to act in ways that are incompatible with their strongly held beliefs.²⁴⁵ Anything short of a pregnant person being able to choose the level of medical supervision that is best for them, could degrade “the conditions in which women must make and act on decisions about abortion.”²⁴⁶ As the Supreme Court has noted, it matters not only whether someone can “ultimately manage to get an abortion,” but also how the State impacts the conditions of that abortion.²⁴⁷

People need to have a range of interaction levels with medical professionals.²⁴⁸ While many people prefer clinic-based abortions, the right to choose should not limit people to only clinic-based care. Instead, a robust reading of the right to choose would also cover a variety of other abortion experiences, including ordering abortion pills from a pharmacy and having the pills shipped directly to a person's home (where the person would only interact with a doctor in the event of a rare complication), as well as a person taking an abortifacient provided by an indigenous healer, midwife, herbalist, curandera, or trusted friend, instead of a doctor. Since legislatures are increasingly regulating how abortions are performed by others, it is time for the legal community to develop a constitutional

regulating abortion were designed to provide protections against unsafe tinctures and were not specifically designed to regulate ending a pregnancy. *See, e.g.*, Reagan, *supra* note 195, at 10 (noting the first statutes regulating abortion, passed in the 1820s and 1830s, were actually poison-control laws, including the 1827 Illinois law, which prohibited the provision of abortifacients, was listed under “poisoning” not as a regulation of abortion). The first abortion laws “said nothing about growing the plants needed in one's own garden or mixing together one's own home remedy in order to induce an abortion.” *Id.* Some scholars have suggested the “legal silence on domestic practices” is evidence of an attempt to regulate the commercialization of abortion practice and that women “implicitly retained . . . the right to make their own decisions about their pregnancies.” Reagan, *supra* note 195, at 10. There is evidence many abortions in 1800s were performed in the home using self-administered abortifacients purchased through midwives, doctors, and through the mail. *See* Reagan, *supra* note 195, at 25. This historical framework for self-abortion and the law is relevant to a fundamental rights analysis of self-induced abortion.

244. Only twelve states plus the District of Columbia do not require an abortion to be performed by a physician. GUTTMACHER INST., AN OVERVIEW OF ABORTION LAWS (Feb. 1, 2017), http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf.

245. *See, e.g.*, *In re A.C.* 573 A.2d 1235, 1257–58 (D.C. 1990) (en banc); *see also* Cruzan *ex rel.* Cruzan v. Harmon 760 S.W.2d 408 (Mo. 1988), *aff'd sub nom.* Cruzan *ex rel.* Cruzan v. Director of Mo. Dep't of Health, 110 S. Ct. 2841, 2846–47 (1990) (discussing a person's right to make their own medical decisions).

246. Greenhouse & Siegel, *supra* note 219, at 161 (citing *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2313 (2016)).

247. *Id.*

248. For a discussion of the importance of privacy of medical decisions to people securing abortions, see generally Thoai D. Ngo et al., *Comparative Effectiveness, Safety and Acceptability of Medical Abortion at Home and in a Clinic: A Systematic Review*, 89 BULL. WORLD HEALTH ORG. [WHO] 360, 360–70 (2011), <http://www.who.int/bulletin/volumes/89/5/10-084046/en/>.

analysis²⁴⁹ that recognizes the right²⁵⁰ to have an abortion “free from the protective paternalism of either her physician or the state.”²⁵¹

While the *Roe* decision clearly covers a physician’s right to perform an abortion, *Roe* can also be read as a command to reduce the role doctors need to play in some aspects of abortion.²⁵² While some doctors had pushed for laws that

249. Potential constitutional footings for such a right would include finding that criminalization or regulation of self-induced abortion is a violation of a Fifth Amendment right to due process because it is an infringement of a fundamental right that requires strict scrutiny. See Scout Richters, *The Moral Interception of Oral Contraception: Potential Constitutional Claims Against the FDA’s Prescription Requirement for A Progestin-Only Birth Control Pill*, 22 J.L. & POL’Y 393, 416–17, 431 (2014) (concluding that the FDA’s requirement to see a physician before being prescribed certain birth control pills violates the Supreme Court’s holding in *Eisenstadt*). Alternatively, such a constitutional analysis could conclude there is no rational basis for requiring the current level of required medical examination and supervision for all medication abortions. See, e.g., *Miller v. Med. Ass’n of Ga.*, 423 S.E.2d 664, 665 (Ga. 1992) (acknowledging that self-injection of insulin violated equal protection and due process because it was so broad that it prohibited conduct that “there is no rational basis to prohibit.”); Heather Dixon, Note, *Pelvic Exam Prerequisite to Hormonal Contraceptives: Unjustified Infringement on Constitutional Rights, Governmental Coercion, and Bad Public Policy*, 27 HARV. WOMEN’S L.J. 177, 178 (2004) (concluding the pelvic exam requirement is a “violation of substantive due process rights to contraceptive access, reproductive autonomy, and bodily integrity due to its lack of any rational basis.”). The requirement of seeing a physician in advance of taking abortion pills could be a violation of bodily privacy for those whose values systems prefer self-directed care over physician-directed care. See, e.g., *Winston v. Lee*, 470 U.S. 753, 761 (1985); *Rochin v. California*, 342 U.S. 165, 172 (1952). Additionally, the physician-only requirement for those who prefer self-induced methods may be an unconstitutional condition on the exercise of fundamental reproductive privacy rights in states where abortion coverage mandates a visit to a physician and an ultrasound (or other testing) before public funds will cover the abortion. See *infra* Part II.A.2.a. for a full discussion of how the courts have applied the unconstitutional conditions doctrine. Lastly, the requirement of requiring a visit to a doctor could constitute a violation of the Free Exercise Clause of the First Amendment for those whose deeply held beliefs require self-directed herbal or medical abortions from a spiritual healer or other non-physician provider. See, e.g., *Harris v. McRae*, 448 U.S. 297, 320–321 (requiring a challenge of an abortion law under the free exercise clause provide a basis for a religious belief that would require such a practice); Note, *Compulsory Medical Treatment and the Free Exercise of Religion*, 42 IND. L. J. 386 (concluding the free exercise clause may provide a basis for refusing an objected medical treatment unless there is a compelling government interest for requiring an objected medical treatment).

250. Clearly, such a right would not foreclose the right to a clinic-based abortion. For many people, an abortion at an abortion clinic will remain the best way to experience an abortion. But, some may prefer an abortion experienced at home, or other safe place, surrounded by their chosen companion with little or no medical assistance. Such a self-directed abortion can be both safe and effective. See, e.g., Caitlin Shannon & Beverly Winikoff, *How Much Supervision is Necessary for Women Taking Mifepristone and Misoprostol for Early Medical Abortion?*, 4 WOMEN’S HEALTH 107, 110 (2008); Wainwright et al., *supra* note 242, at 162. We believe that developing jurisprudence that supports a right to self-determined abortion care could ultimately bolster legal theories that support the repeal of abortion coverage bans and other politically motivated abortion restrictions because if a person has the right to determine the method of abortion, they must also have the financial resources to have this be a meaningful decision.

251. Susan Frelich Appleton, *More Thoughts on the Physician’s Constitutional Role in Abortion and Related Choices*, 66 WASH. U. L. Q. 499, 512 (1988) (suggesting medication abortion could provide an opportunity to re-think the legal basis for a physician’s role in abortion).

252. Clearly the *Roe* Court justified access to abortion in terms of privacy rights but also in terms of the clinical autonomy of doctors and the sanctity of the doctor–patient relationship. But, note that since the Court’s decision in *Roe* the Court has somewhat narrowed the importance of the physician. See, e.g., *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 421 n.1 (1983) (“[A] woman has a fundamental right”); Yvonne Lindgren, *Rhetoric of Choice: Restoring Healthcare to the Abortion Right*,

would allow *only* them to decide when an abortion should be performed,²⁵³ the Court did not grant this power, instead giving autonomy to the pregnant person.²⁵⁴ *Roe*, therefore, took some of the power away from the doctors and hospital review boards, and instead allowed early abortions to be provided for the pregnant person's own reasons without a requirement of "therapeutic" necessity.²⁵⁵ After *Roe*, a pregnant person could secure an abortion for their own reasons,²⁵⁶ instead of needing to provide a doctor with the physical or mental health reason for the abortion, receive testing for fetal abnormalities, or tell their doctor if the pregnancy was caused by rape or incest.

Evidence suggests that pregnant people are able to: a) decide whether to have an abortion;²⁵⁷ b) accurately recall the date of their last menstrual cycle (which is necessary²⁵⁸ to know whether abortion pills are contraindicated);²⁵⁹ c) determine whether they have any of the contraindications;²⁶⁰ and d) make an informed

64 HASTINGS L. J. 385, 403–04 (2013) (noting that the *Gonzales* decision does not completely rest on medical judgment since the procedure outlawed was widely supported by the medical community but the Court chose to uphold the legislature's judgment). Additionally, many scholars suggest that the emphasis on the medical profession is misplaced. See, e.g., LAURENCE H. TRIBE, ABORTION: THE CLASH OF ABSOLUTES 45 (1990) (critiquing the role of doctors in the abortion decision since this would reinforce "the traditional role of the woman as dependent, without control over her future"); Appleton, *supra* note 251, at 499, 507; Ruth Bader Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. REV. 1185, 1199–200 (1992) (discussing the pregnant woman's right to "free exercise of her physician's medical judgment"); Linda Greenhouse, *How the Supreme Court Talks About Abortion: The Implications of a Shifting Discourse*, 42 SUFFOLK U. L. REV. 41, 42 (2008); Reva B. Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 277–81 (1992).

253. See Siegel, *supra* note 252, at 287–89.

254. *Id.*; see also *Roe v. Wade*, 410 U.S. 113, 162 (1973).

255. See Drew Halfmann, *Historical Priorities and the Responses of Doctors' Associations to Abortion Reform Proposals in Britain and the United States, 1960–1973*, 50 SOC. PROBS. 567, 567 (2003).

256. Most people who have abortions are highly confident in their decision to have an abortion—both before and after having an abortion. As such, while some people may desire to consult with a doctor regarding whether an abortion is medically the right option for them, there is no reason a doctor must play a gatekeeping role for women as they make decisions on abortion. See generally Lauren J. Ralph et al., *Measuring Decisional Certainty Among Women Seeking Abortion*, 95 CONTRACEPTION 269 (Oct. 10, 2016), <http://www.sciencedirect.com/science/article/pii/S0010782416304103>.

257. *See id.*

258. See *Bold Action*, *supra* note 53, at 610.

259. Nine of ten women are able to estimate their gestation based on their last menstrual period accurately enough to use mifepristone and misoprostol on their own. Charlotte Ellertson et al., *Accuracy of Assessment of Pregnancy Duration by Women Seeking Early Abortions*, 355 LANCET 877, 878–79 (2000); see *Bold Action*, *supra* note 53, at 610. See generally Kelly Blanchard et al., *A Comparison of Women's, Providers' and Ultrasound Assessments of Pregnancy Duration Among Termination of Pregnancy Clients in South Africa*, 114 BJOG INT'L J. OBSTETRICS & GYNAECOLOGY 569 (2007).

260. Premila W. Ashok et al., *A Randomized Comparison of Medical Abortion and Surgical Vacuum Aspiration at 10–13 Weeks Gestation*, 17 HUM. REPROD. 9 (2002); Shannon & Winikoff, *supra* note 250, at 108 ("With the exception of nonuterine pregnancy, contraindications are based on medical history. For this reason, the vast majority of women are aware when they have a contraindicated condition, such as an intra-uterine device in place, chronic adrenal failure, concurrent long-term corticosteroid therapy, history of allergy to mifepristone, misoprostol or other prostaglandin, hemorrhagic disorders or concurrent

decision about whether to take abortion pills without first consulting with a physician. Additionally, people who self-induce abortions are similarly able to follow post-procedure instructions.²⁶¹

While historically lawmakers could point to safety as a rationale for having the abortion experience controlled by doctors, abortion pills²⁶² rebuke assumptions of danger, as they are safe to use with less supervision,²⁶³ control, or other involvement by a physician.²⁶⁴

anticoagulant therapy.”); *see also* Beth Kruse, *Management of Side Effects and Complications in Medical Abortion*, 183 AM. J. OBSTETRICS GYNECOLOGY 65, 65–75 (2002); Caitlin Shannon, *Ectopic Pregnancy and Medical Abortion*, 104 OBSTETRICS & GYNECOLOGY 161, 164–65 (2004).

261. *See generally* Caitlin Shannon, *Infection After Medical Abortion: A Review of the Literature*, 70 CONTRACEPTION 183 (2004).

262. We use the phrase “abortion pills” to broadly cover either the two-drug regimen (mifepristone and misoprostol) used for medication abortions in most (if not all) abortion clinics or a single drug regimen of misoprostol, because there is medical support for both options. In addition to pharmaceutical pills, herbs continue to be the only or preferred option for many specific populations, including for people that usually use herbs and alternative medicine, immigrants with specific connections to herbs, herbal healers, and others. Additionally, there is a connection between herbs and pharmaceutical abortion pills, since many people will use herbs as support before and after taking pharmaceutical pills. As such, even if the herbs are not intended to be the method of abortion itself, the herbs may be used in conjunction with other methods, like herbs and misoprostol or herbs and menstrual extraction. For a general discussion of the public health research on herbs for abortion, *see* Alison Ojanen-Goldsmith, *Harvesting the Evidence: Medicinal Plant and Herb Use in Abortion Care*, 92 CONTRACEPTION 401, 401–02 (2015). Because there have been no comprehensive studies of the safety and efficacy of herbs for abortions, we will focus here on pharmaceutical pills.

263. *See* Wainwright et al., *supra* note 242, at 163 (concluding there is support among medical providers for self-management of abortion where people are provided with the following information: 1) the fact that abortion medications should not be confused with emergency or oral contraception; 2) how to take the medication correctly; 3) what to expect after taking the medication; 4) possible side effects and how to deal with them; 5) how to plan for the management of the miscarriage process at home; 6) the appropriate use of painkillers; and 7) how to identify when further medical help is required); *see also* Elizabeth G. Raymond et al., *Reaching Women Where They Are: Eliminating the Initial In-Person Medical Abortion Visit*, 92 CONTRACEPTION 190, 190 (2015); Shannon & Winikoff, *supra* note 250, at 108, 110; Natalie S. Whaley & Anne E. Burke, *Update on Medical Abortion: Simplifying the Process for Women*, 27 CURRENT OP. OBSTETRICS & GYNECOLOGY 476, 476–77 (2015).

264. *See* Jill Filipovic, *Should Women Perform Their Own Abortions?*, COSMOPOLITAN (Oct. 3, 2016), <http://www.cosmopolitan.com/politics/a4370287/diy-abortions-indonesia-samsara/>; *see also* WHO, SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS: SECOND EDITION 44 (2012), http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1; Hillary Bracken et al., *Home Administration of Misoprostol for Early Medical Abortion in India*, 108 INT’L. J. GYNECOLOGY & OBSTETRICS 228, 231–32 (2010) (explaining that when women were offered a choice of whether to have an abortion at home or in a clinic, this study shows that women having abortions at home have a similarly positive experience to those who have the abortion at a clinic); John K. Jain et al., *A Prospective Randomized, Double-blinded, Placebo-controlled Trial Comparing Mifepristone and Vaginal Misoprostol to Vaginal Misoprostol Alone for Elective Termination of Early Pregnancy*, 17 HUM. REPROD. 1477, 1481–82 (2002); Kevin Sunde Oppegaard et al., *Clinical Follow-up Compared with Self-Assessment of Outcome After Medical Abortion: A Multicentre, Non-inferiority, Randomised, Controlled Trial*, 385 LANCET 698, 698, 701–02 (2015) (concluding abortion medication can be safely and effectively ingested without a licensed medical professional being present); *Doctors Let 50 Women Abort Babies at Home*, SCOTSMAN (July 3, 2005, 12:02 A.M.), <http://www.scotsman.com/news/doctors-let-50-women-abort-babies-at-home-1-1391468> (“I was very surprised by the level of acceptability to home abortion amongst women. I thought it would be frightening for women and they would want to be with the necessary staff

It is not difficult to imagine situations in which the physician might play, at most, a minimal role. . . . [T]his patient may use this pill to terminate a subsequent pregnancy without consulting a physician about this particular abortion. Finally, a physician might prescribe a substance like [the abortion pill] for a patient to use in the event of a subsequent late menstrual period, without further physician consultation at the time the drug is ingested, or to use regularly to prevent or interrupt unplanned pregnancies.²⁶⁵

The understanding that people are capable of following instructions and seeking appropriate follow up has led the FDA to facilitate the self-directed use of a variety of medications and treatments through the practice of informative labeling.²⁶⁶ Take for example the FDA's approval of over-the-counter products like emergency contraception,²⁶⁷ to behind-the-counter products available from a pharmacist, such as oral contraceptives,²⁶⁸ to prescribed but self-administered treatments, such as self-injection of insulin by diabetics²⁶⁹ and home-based dialysis.²⁷⁰ In fact the very same drug used in many self-administered medication abortions, misoprostol, is already available for patient-directed use in other forms of obstetric care (e.g., spontaneous miscarriage management, postpartum hemorrhage).²⁷¹

who can give them support through the procedure and reassure them. But women who experienced it for real genuinely felt it was something they could cope with in the home. Many preferred their own choice of companions they could have in their own home, and being able to use their own toilet facilities.”)

265. Appleton, *supra* note 251, at 511.

266. See Tummino v. Hamburg, 936 F. Supp. 2d 162, 172–73 (S.D.N.Y. 2013).

267. See *Emergency Contraception*, GUTTMACHER INST. (Jan. 1, 2017), <https://www.guttmacher.org/state-policy/explore/emergency-contraception>.

268. See Scout Richters, *The Moral Interception of Oral Contraception: Potential Constitutional Claims Against the FDA's Prescription Requirement for a Progestin-Only Birth Control Pill*, 22 J. L. & Pol'y 393, 408 (2014); Pam Belluck, *Birth Control Without Seeing a Doctor: Oregon Now, More States Later*, N.Y. TIMES (Jan. 4, 2016), <http://www.nytimes.com/interactive/2016/01/04/health/birth-control-oregon-contraception.html>.

269. See, e.g., Miller v. Med. Ass'n of Ga., 423 S.E.2d 664, 665 (acknowledging that self-injection of diabetes should not be prohibited by law and ruling that the statute violated equal protection and due process because it was so broad that it prohibited conduct for which “there is no rational basis to prohibit.”)

270. Eric Whitney, *Feds Say More People Should Try Dialysis at Home*, NPR (Oct. 4, 2016), <http://www.npr.org/sections/health-shots/2016/10/04/492932675/feds-say-more-people-should-try-dialysis-at-home> (concluding patients do better if they're more active participants in their care, rather than passive receivers—noting that patients who switch from the largely passive experience of a center to taking responsibility for their own care at home never want to go back, “even when we've had people having significant problems and issues” doing it themselves. Of course, “[n]either Medicare nor Maddux will say how many more dialysis patients should do the procedure at home. They say that is both a personal and medical choice that isn't right for everyone, and they don't want patients who are happy using dialysis centers to feel pressure to change.”)

271. See, e.g., GYNUITY HEALTH PROJECTS, INSTRUCTIONS FOR USE: MISOPROSTOL FOR TREATMENT OF POSTPARTUM HEMORRHAGE 2 (Sept. 2015), http://gynuity.org/downloads/clinguide_ifu_pphprevention_en.pdf (concluding “Advance distribution of misoprostol to pregnant women for self-use after childbirth is a safe and effective way to prevent excessive bleeding among women who deliver at home” since research

Scholars, advocates, and the legal community could use this robust reading of the right to choose in a number of ways that may help improve self-directed access to abortion pills. For example, this theory could be used to challenge the onerous restrictions the FDA imposes on clinicians that prescribe the only FDA-approved abortion pills—which public health experts, doctors, and legal scholars agree there is no “demonstrated or even reasonably likely advantage” to imposing.²⁷² Additionally, this legal theory could eventually be used to make abortion pills available over-the-counter or through improved pharmacy access, including through online pharmacies, or could allow lay people to distribute abortion pills, like the community-based providers who furnish the FDA-approved drug Narcan to those who need it,²⁷³ or to allow for any number of other shifts in law and policy that would allow for self-directed abortion care. Such shifts in law and policy are essential to ensure a future in which people will have the necessary rights and supports to choose the kind of abortion that’s right for them. This would include provider-directed abortion care in a clinical setting and self-directed abortion care in a home setting. One can read the right to choose abortion as encompassing the right to choose the method, setting, companion, and timing of an abortion. Both the history of self-induced abortion and the safety of current practices support this reading.

CONCLUSION

Novel theories and innovative arguments can help to dislodge precedents, shift paradoxical paradigms, and secure legal victories so that low-income people can make unimpeded decisions about pregnancy that are right for themselves and for their families.

and program experience have demonstrated that women can be taught to self-administer the medicine correctly after childbirth. The authors recommend that misoprostol be distributed to women at the beginning of the third trimester of pregnancy in case the woman delivers early.)

We also note that drawing a distinction between self-administered misoprostol in postpartum hemorrhage may demonstrate that laws requiring abortion pills be distributed only by specific types of providers, that require abortion pills be ingested in a doctor’s office, or that require only physicians perform medication abortion may be based upon ideological grounds, rather than the grounds of any medical or health justification. This is a relevant distinction after the Supreme Court’s decision in *Whole Women’s Health v. Hellerstadt*, 136 S.Ct. 2292 (2016).

272. Mifeprex REMS Study Group, *Sixteen Years of Overregulation: Time to Unburden Mifeprex*, 376 NEW ENG. J. MED. 790 (Feb. 23, 2017) (calling on the FDA to remove the Risk Evaluation and Mitigation Strategy, or REMS, process, which requires the only FDA-approved form of abortion pills be distributed in clinics, medical offices, and hospitals, not in retail pharmacies—mandating a visit to a doctor’s office to secure the pills).

273. Eliza Wheeler et al., *Opioid Overdose Prevention Programs Providing Naloxone to Laypersons—United States, 2014*, 64 MORBIDITY & MORTALITY WKLY. REP. 631 (June 19, 2015), https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6423a2.htm?s_cid=mm6423a2_w.