

Volume 15 | Issue 2

Summer 2012

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Recommended Citation

Cynthia Soohoo, *Hyde-Care for All: The Expansion of Abortion-Funding Restrictions Under Health Care Reform*, 15 CUNY L. Rev. 391 (2012).
Available at: 10.31641/clr150217

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Acknowledgements

The author is grateful to Ruthann Robson, Brigitte Amiri, Jordan Goldberg, Diana Hortsch, Suzannah Phillips, Payal Shah, and Stephanie Toti for their thoughtful comments and suggestions, to Monica Roa for her insights on Colombian law, to Claire Cooper for her excellent research assistance, and to the participants in the South Asia Reproductive Rights Case Development Workshop, hosted by the Center for Reproductive Rights' South Asia Reproductive Justice and Accountability Initiative ("SARJAI") for their insights into South Asian case law. Research for this Article was funded in part by a PSC-CUNY Research Award.

HYDE-CARE FOR ALL: THE EXPANSION OF ABORTION-FUNDING RESTRICTIONS UNDER HEALTH CARE REFORM

Cynthia Soohoo†

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.

Representative Henry Hyde (1977)¹

My hope for the next phase of the movement for procreative and sexual rights is that we not limit ourselves simply to winning back what we have lost, but rather set our sights on winning what we need: recognition of an affirmative right of self-determination This will . . . require recognizing that it is society's responsibility both to protect choice and to provide the material and social conditions that render choice a meaningful right rather than a mere privilege.

Rhonda Copelon (1991)²

The historic health care reform law passed in 2010 has the potential to dramatically increase the number of Americans able to access health care. Health care reform is projected to result in health care coverage for thirty million Americans who are currently uninsured.³ While increasing health coverage is a good thing,

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¹ FREDERICK S. JAFFE ET AL., *ABORTION POLITICS: PRIVATE MORALITY AND PUBLIC POLICY* 127 (1981) (quoting Representative Henry Hyde).

² Rhonda Copelon, *Losing the Negative Right of Privacy: Building Sexual and Reproductive Freedom*, 18 N.Y.U. REV. L. & SOC. CHANGE 15, 16 (1990–1991).

³ CONG. BUDGET OFFICE [CBO], *ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION* 13, tbl. 1 (2012), available at <http://cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>. The CBO estimates a decrease in the number of uninsured to fourteen million by 2014 and thirty million by 2022. *Id.*

health care reform will also dramatically increase the impact that the government will have on the provision of health care. The law achieves broader health care coverage by increasing the number of people covered by Medicaid and creating state insurance exchanges that allow individuals to buy health insurance with premium and cost-sharing credits.⁴ The federal government will set minimum requirements for policies sold on the exchanges, and state governments will have significant power to dictate policy requirements and exclusions. This expansion of government influence over health care can be dangerous if government policies are driven by politics instead of medicine and if no legal or political constraints are imposed to protect individual rights. Nowhere is this danger more pronounced than in government policies around reproductive health and abortion.

Since the 1980 case *Harris v. McRae*, the Supreme Court has held that it is constitutional for the federal government to use its funding of health care services to dissuade women who rely on government health services from having abortions. Under the federal Hyde Amendment, Congress has prohibited the use of federal Medicaid funds to pay for abortion care even where a woman requires an abortion for health reasons since 1976. Over the past thirty-five years, similar restrictions have been imposed on other groups that rely on the federal government for health care, including federal employees and military personnel and their dependents, Native Americans who rely on the Indian Health Services for medical care, Peace Corps volunteers, adolescents covered by the Children's Health Insurance Program ("CHIP"), and women in prison.⁵ The Supreme Court also expanded *Harris's* holding to federal funding in other contexts, upholding laws prohibiting the use of public health facilities or employees in the provision of abortion services and restrictions prohibiting recipients of federal family planning funds from providing counseling or referrals for abortion.⁶

During the 2009 debates around health care reform, anti-

⁴ THE HENRY J. KAISER FAMILY FOUND., SUMMARY OF THE HEALTH CARE LAW 1 (2010).

⁵ JESSICA ARONS & MADINA AGÉNOR, CTR. FOR AM. PROGRESS, SEPARATE AND UNEQUAL: THE HYDE AMENDMENT AND WOMEN OF COLOR 8–9 (2010), available at http://www.americanprogress.org/wp-content/uploads/issues/2010/12/pdf/hyde_amendment.pdf; Heather D. Boonstra, *The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States*, 10 GUTTMACHER POL'Y REV. No. 1 (Winter 2007), available at <http://www.guttmacher.org/pubs/gpr/10/1/gpr100112.pdf>.

⁶ *Rust v. Sullivan*, 500 U.S. 173 (1991); *Webster v. Reprod. Health Servs.*, 492 U.S. 490 (1989).

choice legislators sought to use health care reform to expand the reach of abortion funding restrictions even further by arguing that because some policies offered on the new state insurance exchanges would receive government subsidies, the federal “policy” prohibiting public abortion funding required that exchange policies ban abortion coverage. Rather than questioning the underlying logic of prohibiting federal health care funding for medically necessary abortions, President Obama and supporters of health care reform accepted the Hyde Amendment as the starting point for the debate. In the end, congressional democrats brokered a compromise to defeat proposals to ban exchange policies from covering abortion by creating a complicated accounting procedure to segregate federal subsidies from individual premiums and to only use funds derived from individual premiums “to pay for” abortion care.

However, the political debate took its toll. Now, as we wait for the implementation of health care reform, we are poised to see the Hyde Amendment’s impact dramatically expand. Ironically, the historic extension of health care coverage could result in the largest expansion of abortion funding restrictions since the amendment went into effect in 1977.⁷ In addition to a dramatic increase of the number of women covered by Medicaid, we are seeing state legislative attempts to force the same coverage restrictions upon women who buy their own health insurance on the private market or through the new health care exchanges. These measures were explicitly sanctioned and indirectly encouraged by federal health care reform. The health care reform legislation provides that states may prohibit abortion coverage in the policies offered on their insurance exchanges. Even though the exchanges do not go into effect until 2014, over a third of states have already passed laws to

⁷ Rachel Benson Gold, *Insurance Coverage and Abortion Incidence: Information and Misinformation*, 13 GUTTMACHER POL’Y REV. NO. 4, 8–9 (Fall 2010), available at <http://www.guttmacher.org/pubs/gpr/13/4/gpr130407.pdf>. The Gold report, issued prior to the Supreme Court’s decision in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012), noted that because the Affordable Care Act’s proposed Medicaid expansion would dramatically expand the overall Medicaid program and the effect of the expansion would be “felt disproportionately in states that do not subsidize abortion with their own funds” health care reform posed the “largest expansion of abortion funding restrictions since Hyde was first implemented.” *Id.* Following the Supreme Court’s holding in *Sebelius* that states can opt out of the Medicaid expansion without penalty; it is unclear exactly how great the Medicaid expansion will be. *Id.* It is also unknown whether the states that participate in the Medicaid expansion are likely to be states that use state funds to pay for medically necessary abortions. However, the increase in the number of women subject to abortion funding restrictions is likely to be substantial.

ban abortion coverage on their exchanges.⁸ Further, by incorporating requirements that segregate federal funds so that they are not mixed with insurance premiums that are used to pay for abortion services, the health reform law has encouraged the idea that those who pay insurance premiums should have the right to dictate how insurance companies use the money paid to them. Several states have taken this to the extreme by passing bans on all private insurance coverage for abortion care, irrespective of whether policies are sold on their exchange, arguing that individual insurance buyers may not want their premiums used to pay for abortions. States have also sought to use the withdrawal of funding to punish health care providers associated with abortion by adopting measures to cut Planned Parenthood funding.⁹

While opponents of health care might argue that this type of overreaching is precisely why government should not be involved in the provision of health care coverage, the proper response is not to double-down on a negative rights paradigm that only protects women's right to be free from undue government interference. Instead, I argue that the Supreme Court made a wrong turn in 1980 when it held that the government could use its funding of health care services for the poor to further an anti-choice agenda based on a formalistic distinction between government-imposed obstacles and government exercise of its discretion to make funding choices to further its policy objectives.

In the wake of *Harris v. McRae*, progressive scholars and reproductive justice activists articulated the need for an affirmative concept of reproductive autonomy, which requires that government policies and programs actively support, rather than undermine the exercise of fundamental rights. Although Supreme Court decisions post-*Harris* have only reinforced the concept of reproductive freedom as a negative right, the concept that privacy and autonomy rights include affirmative government obligations has found support in international human rights law and in the decisions of high courts in other countries.¹⁰ Further, as illustrated by state court cases holding that abortion funding restrictions violate fundamental rights protected by state constitutions, there is substantial support for construing even a negative privacy right to prohibit discriminatory government benefit programs that seek to coerce women's constitutional choices.

⁸ See *infra* note 143 and accompanying text.

⁹ See *infra* notes 147 and 153 and accompanying text.

¹⁰ See *infra* notes 36–40 and Parts IV.A, C.

The first part of this Article examines critiques of the development of reproductive autonomy as a negative privacy right and arguments made by progressive scholars and the reproductive justice movement to adopt an affirmative right to reproductive autonomy. The second part looks at the Supreme Court's abortion funding cases from 1977 to 1980 and a related set of cases concerning prohibitions on the use of public medical facilities or staff to perform abortions and the prohibition of federal funding to organizations that provide or refer women to doctors or organizations that provide abortion services. These decisions allowed the federal and state governments to use their funding programs to impose substantial obstacles in the path of women seeking access to abortion care. The third part examines how the Hyde Amendment restrictions have been expanded by recent laws banning insurance coverage for abortion care on state insurance exchanges and in the private market and funding restrictions targeting Planned Parenthood. The fourth part of this Article looks at alternative ways of analyzing public and private health insurance restrictions on abortion coverage by considering state court cases, international law, and the decisions of high courts in Canada, Colombia, and Nepal.

I. AN AFFIRMATIVE VISION OF REPRODUCTIVE HEALTH AND AUTONOMY

In April 1980, eight years after the Supreme Court decided *Roe v. Wade*,¹¹ Professor Rhonda Copelon appeared before the Court to argue the abortion funding case *Harris v. McRae*. Following *Roe*, the Supreme Court issued a number of decisions applying *Roe*'s strict scrutiny standard to invalidate abortion restrictions.¹² The exceptions to this string of victories were two 1977 cases, *Beal v. Doe*¹³ and *Maher v. Roe*,¹⁴ which held that states were not obligated to cover non-therapeutic abortions—abortions that are not necessary

¹¹ *Roe v. Wade*, 410 U.S. 113 (1973) *holding modified by* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992).

¹² Linda J. Wharton et al., *Preserving the Core of Roe: Reflections on Planned Parenthood v. Casey*, 18 YALE J.L. & FEMINISM 317, 324 & n. 32 (2006) (noting that with the exception of funding cases, the Supreme Court applied *Roe*'s strict scrutiny standard to strike down most abortion restrictions until 1989); KATHLEEN M. SULLIVAN & GERALD GUNTHER, CONSTITUTIONAL LAW 430 (17th ed. 2007) ("As to adult women, restrictions on public subsidies were the only abortion regulations upheld in the period between *Roe* and *Casey*.").

¹³ *Beal v. Doe*, 432 U.S. 438 (1977).

¹⁴ *Maher v. Roe*, 432 U.S. 464 (1977).

for health reasons—under state Medicaid programs.¹⁵

Although the Supreme Court had upheld state restrictions prohibiting Medicaid funding for non-therapeutic abortion, there was significant reason to think that the Court could find *Harris* distinguishable. The federal funding restrictions in *Harris* went significantly further than the state restrictions in *Beal* and *Maher*. In those cases, the Supreme Court held that state regulations could limit state Medicaid coverage to medically necessary abortions and prohibit funding for abortions that were not needed for medical reasons. The federal Hyde Amendment at issue in *Harris* prohibited the use of federal Medicaid funds to cover medically necessary abortions, only allowing coverage where an abortion was required because a woman's life was endangered or if the pregnancy resulted from rape or incest.¹⁶

The *Harris* majority rejected due process, equal protection, Establishment Clause, and statutory challenges to the discriminatory funding scheme and upheld the Hyde Amendment. Although the abortion funding cases were a setback for reproductive rights activists, the decisions were widely understood as turning on the distinction between government restrictions and government failure to fund. Thus, the government's decision not to fund an activity was not viewed as an overall threat to women's constitutional right to abortion services.¹⁷

However, Copelon did not underestimate the significance of the abortion funding cases, writing in 1991 that the decisions turned the right articulated in *Roe v. Wade* into "the right to be free of barriers to abortion interposed by the state."¹⁸ She lamented that "[t]he divergence between the right to abortion and the reality of access transformed abortion from a privacy right into a privilege."¹⁹ Copelon also criticized the "pro-choice" movement for failing to recognize how *Harris* undermined core principles of *Roe*.

¹⁵ *Maher*, 432 U.S. at 465–66, 469. In *Maher*, the Supreme Court rejected constitutional challenges to state exclusions of nontherapeutic abortions, and in *Beal*, it rejected statutory claims under Title XIX, which sets forth federal requirements for state programs. *Id.*

¹⁶ *Harris v. McRae*, 448 U.S. 297, 302–03 (1980). Since 1976, the Hyde Amendment has passed as an amendment to the annual appropriations bill or as a joint resolution. The original Hyde Amendment did not include an exception for rape or incest. *Id.*

¹⁷ See Wharton et al., *supra* note 12, at 324 (writing that most abortion restrictions were struck down under *Roe*'s strict scrutiny standard until the "constitutional tide" turned in 1989).

¹⁸ Copelon, *supra* note 2, at 17.

¹⁹ *Id.* See Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade*, 63 N.C. L. REV. 375, 384 (1985) (stating that after *Harris* the Court was

She suggested that the failure of middle class women to fight against restrictions that undermined poor women's access to services opened the door to increasing abortion restrictions introduced in the late 1980s and early 1990s:

Indeed, there can be no clearer example of the principle that no right is secure if it is not secure for everybody. Had more privileged women poured out in opposition to the cutbacks on Medicaid . . . , there might be less question today about the security of the right to abortion, the funding of abortions, or the Bill of Rights itself. While many pro-choice and feminist organizations did vigorously oppose the Medicaid cutoffs, the fact that Medicaid was an issue of poor people's rights severely narrowed the base of support and the scope of outreach efforts directed toward a significantly libertarian constituency for reproductive choice.²⁰

In a 1991 article, Copelon discussed the tension between the liberal notion of privacy “characterized as the negative and qualified right to be left alone” and “the more radical ideal of privacy, depicted as the positive liberty of self-determination and equal personhood.”²¹ She wrote that the negative theory of privacy is problematic because it assumes that if the government does not impose any interference with a woman's reproductive autonomy and health, she is free to exercise her choice and any failure to effectuate her choice results from her own failure.²² This theory fails to recognize the role that social conditions play and the state's role in creating those conditions.²³ It also denies any public responsibility for ensuring that individuals are able to exercise autonomy.²⁴ In fact, as discussed below,²⁵ the Supreme Court has interpreted the negative concept of privacy to allow the state to condition health care benefits upon a woman opting to continue pregnancy rather than obtain an abortion even if the pregnancy endangers her health.

A. *The Reproductive Justice Movement*

In the 1990s, women of color activists articulated similar and broader concerns about the mainstream pro-choice movement.

accused of sensitivity to only the Justices' “own social milieu—‘of creating a middle class right to abortion’”).

²⁰ Copelon, *supra* note 2, at 22.

²¹ *Id.* at 41.

²² *Id.* at 46.

²³ *Id.*

²⁴ *Id.* at 44, 47.

²⁵ *See infra* Part II.A-C.

They questioned the movement's over-reliance on legal rights and strategies, given the cramped constitutional vision articulated by the Supreme Court and the consistent failure of legal recognition of reproductive rights to translate to actual access for low-income women.²⁶ Activists involved in what would become the reproductive justice movement called out reproductive rights activists for failing to see the racial implications of reproductive health laws and policies and for only focusing on issues that affect white middle class women. In particular, the reproductive justice movement criticized the pro-choice movement for focusing too narrowly on the legal right to abortion and for failing to address laws and policies that undermine the choice of women of color to have children.²⁷ Instead reproductive justice "emphasizes that women have a right to have or not have children, as well as to parent the children they have."²⁸

Significantly, reproductive justice scholars and activists contend that full realization of reproductive rights requires more than a negative privacy right. A reproductive justice analysis "recognizes that 'enabling conditions' are necessary to realize these rights."²⁹ Thus, reproductive justice requires the recognition of an affirmative government duty "to facilitate the processes of choice and self-determination."³⁰

Reproductive justice activists also have been critical of the reproductive rights movement's overreliance on litigation strategies

²⁶ Sarah London, *Reproductive Justice: Developing A Lawyering Model*, 13 BERKELEY J. AFR.-AM. L. & POL'Y 71, 77 (2011).

²⁷ *Id.* at 75.

²⁸ Cynthia Soohoo & Suzanne Stolz, *Bringing Theories of Human Rights Change Home*, 77 FORDHAM L. REV. 459, 497 (2008) (citing Loretta Ross, *Understanding Reproductive Justice* 1-2 (2006) (unpublished paper, on file with author)).

²⁹ *Id.*

³⁰ DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* 309 (1997). See Timothy Zick, *Re-Defining Reproductive Freedom: Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, 21 HARV. WOMEN'S L.J. 327, 331 (1998); Robin West, *From Choice to Reproductive Justice: De-Constitutionalizing Abortion Rights*, 118 YALE L.J. 1394, 1403 (2009) (writing that "what the Court created in [*Roe*] is not a right to legal abortion; it is a negative right against the criminalization of abortion in some circumstances To be a meaningful support for women's equality or liberty, a right to legal abortion must mean much more than a right to be free of moralistic legislation that interferes with a contractual right to purchase one. It must guarantee access to one."); London, *supra* note 26, at 71 (noting that the "mainstream reproductive rights movement has historically dodged the question of public resources" in contrast with the reproductive justice movement which "refuses to ignore the question of public resources—recognizing that a legal right to reproductive services, without support, leaves many women without meaningful choice.").

because they are ill equipped to address barriers to access or create the political pressure needed to catalyze the adoption of laws and policies to support women's reproductive autonomy. They argue that by defining problems in legal terms, the reproductive rights movement has marginalized issues that cannot be expressed in the existing rights framework and has concentrated the movement's leadership in the legal elite rather than in communities.³¹ Because the right to abortion as constitutionalized by the Supreme Court is essentially a negative right, feminist scholar Robin West concurs that it is too narrow to address the concerns and demands of the reproductive justice movement.³² Because "the Court has consistently read the Constitution as not including positive rights" and it "is so unlikely as to be a certainty that [the Court] will commence a jurisprudence of positive constitutional rights, by beginning [with] mandating public funds for abortion," she contends that the right to abortion might be better secured through political or legislative victories than through a strategy that relies on rights adjudicated by the courts.³³

While the reproductive justice movement accurately critiques reproductive rights strategies that have resulted in a disproportionate focus on lawyers and courts, crowding out other strategies, fora and actors,³⁴ it may be too quick to dismiss rights arguments. Although the Supreme Court has consistently refused to recognize affirmative government obligations to ensure rights, human rights bodies are increasingly recognizing a broader conception of rights that require the state to take steps to enable individuals to exercise their fundamental rights.

B. *Human Rights Standards*

As the struggle for reproductive rights in the United States led women of color and progressive scholars like Copelon and West to articulate an alternative affirmative vision of women's reproductive rights, the international human rights community began to develop the concept that governments have obligations to ensure as well as respect fundamental rights. In the last twenty years, international human rights law and the decisions of high courts from many countries have begun to articulate a methodology for enforc-

³¹ London, *supra* note 26, at 85–86.

³² West, *supra* note 30, at 1403–404.

³³ *Id.*

³⁴ London, *supra* note 26, at 85.

ing affirmative obligations.³⁵ Although the majority of scholarship and decisions around affirmative government obligations has focused on socio-economic rights, there is growing recognition that civil and political rights often require the development of government programs and expenditures.³⁶

The International Covenant on Civil and Political Rights (“ICCPR”) requires parties to the treaty to “respect and to *ensure*” the rights set forth in the treaty.³⁷ The U.N. Human Rights Committee, which monitors implementation of the ICCPR, has interpreted the treaty to encompass both negative and positive obligations.³⁸ In particular, it has stated that ratifying countries should “adopt legislative, judicial, administrative, educative and other appropriate measures in order to fulfill their legal obligations” under the treaty.³⁹ The South African Constitution similarly provides that the state “must respect, protect, promote and fulfill the rights in the Bill of Rights.”⁴⁰

These dialogues among human rights activists, progressive feminist scholars, and women of color activists nurtured and strengthened each other. After *Harris v. McRae*, Copelon became a leading international women’s human rights scholar. In the 1990s, she and other feminist scholars and activists worked to transform the international human rights movement to ensure that human rights law reflected the concerns of women and to address human rights violations committed against them. One of their key accom-

³⁵ Comm. on Economic, Social, and Cultural Rights [CESCR], General Comment No. 3, The Nature of States Parties’ Obligations (Art. 2, Para. 1, of the Covenant), U.N. Doc. E/1991/23 (Dec. 14, 1990), available at <http://www.unhcr.org/refworld/docid/4538838e10.html>. See also Malcolm Langford, *The Justiciability of Social Rights: From Practice to Theory*, in SOCIAL RIGHTS JURISPRUDENCE: EMERGING TRENDS IN INTERNATIONAL AND COMPARATIVE LAW 3, 22–24 (Malcolm Langford ed., 2008).

³⁶ Cynthia Soohoo & Jordan Goldberg, *The Full Realization of Our Rights: The Right to Health in State Constitutions*, 60 CASE W. RES. L. REV. 997, 1006–1007 (2010). See, e.g., *Airey v. Ireland*, 2 Eur. Ct. H.R. (Ser. A) 305, 315 (1979) (holding that the right to a fair and public hearing requires access to counsel in civil cases).

³⁷ International Covenant on Civil and Political Rights, art. 2, Dec. 16, 1966, 999 U.N.T.S. 171, available at <http://www.unhcr.org/refworld/docid/3ae6b3aa0.html>. See Soohoo & Goldberg, *supra* note 36, at 1011; Rhonda Copelon, *The Indivisible Framework of International Human Rights: A Source of Social Justice in the U.S.*, 3 N.Y. CITY L. REV. 59, 65–66 (1998).

³⁸ See Human Rights Comm., General Comment No. 31 [80], The Nature of the General Legal Obligation Imposed on States Parties to the Covenant, ¶ 6, U.N. Doc. CCPR/C/21/Rev.1/Add.13 (May 26, 2004), available at <http://www.unhcr.org/refworld/docid/478b26ae2.html> (“The legal obligation under article 2, paragraph 1, is both negative and positive in nature.”).

³⁹ *Id.* at ¶ 7.

⁴⁰ S. AFR. CONST. § 7(2), 1996, available at <http://www.unhcr.org/refworld/docid/3ae6b5de4.html>.

plishments was the recognition of reproductive rights as human rights at the International Conference on Population and Development (“ICPD”) in Cairo in 1994. Members of the U.S. black women’s caucus attended the ICPD and were inspired by the ways in which the human rights concepts developed by international activists addressed the very concerns they were struggling with at home.⁴¹ Following the conference, Sistersong, a leading reproductive justice organization, embraced a human rights framework for its work, explaining that “[h]uman rights provides more possibilities for our struggles than the privacy concepts the pro-choice movement claims only using the U.S. Constitution.”⁴²

II. THE ROAD WE TRAVELED: U.S. ABORTION FUNDING CASES

In the 1970s, when attempts to directly challenge *Roe* in the courts or by a proposed constitutional amendment failed, anti-choice legislators targeted abortion funding as an alternative strategy.⁴³ Their attention turned to the Medicaid program, which provides public health care funding for the poor. Medicaid is administered by the states, but in order to receive partial federal reimbursement for costs, states must abide by certain federal requirements set out in Title XIX of the Social Security Act.⁴⁴ After *Roe v. Wade* struck down criminal restrictions on abortion in 1973, abortion care was routinely covered by most state Medicaid programs.⁴⁵ In 1977, before the Hyde Amendment went into effect,

⁴¹ *Why is Reproductive Justice Important for Women of Color?*, SISTERSONG, available at http://www.sistersong.net/index.php?option=com_content&view=article&id=141&Itemid=81 (last visited Dec. 21, 2012).

⁴² *Id.*

⁴³ JAFFE ET AL., *supra* note 1, at 128.

⁴⁴ CTR. FOR REPROD. RIGHTS, WHOSE CHOICE: HOW THE HYDE AMENDMENT HARMS POOR WOMEN 18 [hereinafter WHOSE CHOICE], available at http://reproductiverights.org/sites/ctr.civicactions.net/files/documents/Hyde_Report_FINAL_nospreads.pdf; *Harris v. McRae*, 448 U.S. 297, 301 (1980); *Women of the State of Minn. by Doe v. Gomez*, 542 N.W.2d 17, 21 (Minn. 1995). See 42 U.S.C. § 1396 (2010) (establishing the Medicaid and CHIP Payment and Access Commission).

⁴⁵ JAFFE ET AL., *supra* note 1, at 128. See, e.g., *Comm. To Defend Reprod. Rights v. Myers*, 625 P.2d 779, 782 (Cal. 1981) (noting that prior to legislation passed in 1978, Medi-Cal paid for abortions obtained by Medi-Cal recipients); *Right to Choose v. Byrne*, 450 A.2d 925, 928 (N.J. 1982) (“In the three years between the *Roe v. Wade* decision and the enactment of [state legislation] in 1975, New Jersey did not restrict state Medicaid funding for abortion.”); *Gomez*, 542 N.W.2d at 23 (stating that within months of *Roe*, Minnesota’s policy was to reimburse for all abortions performed by a licensed provider); *Doe v. Maher*, 515 A.2d 134, 135–136 (Conn. Sup. Ct. 1986) (explaining that shortly after *Roe*, Connecticut provided coverage for therapeutic abortions).

Medicaid funded almost a quarter of the abortions in the United States.⁴⁶

Congressional attempts to prevent Medicaid coverage for abortion care began as early as 1973, but initially were unsuccessful. Although then-Congressman Henry Hyde saw Medicaid funding as a potentially powerful weapon to prevent abortions,⁴⁷ even members of his own ranks expressed concern that the restrictions discriminated against the poor. The pro-life Chair of the Labor-Health Education and Welfare Appropriations Committee denounced Hyde's proposal as "blatantly" discriminatory:

It does not prohibit abortion. It prohibits abortion for poor people To accept the right of this country to impose on its poor citizens . . . a morality which it is not willing to impose on the rich as well—we would not dare do that. This is what this amendment does It is a vote against the poor people.⁴⁸

Despite the concerns expressed about denying abortion coverage for low-income women, between 1973–75 several states imposed restrictions on abortion coverage in their state programs.⁴⁹ In 1976, Congress passed the Hyde Amendment as an amendment to the annual appropriations bill for the Department of Health, Education, and Welfare. The amendment prohibited the use of federal funds to pay for an abortion unless a woman's life was endangered. Subsequent versions of the Hyde Amendment added an exception for victims of rape or incest.⁵⁰

The state and federal funding restrictions were quickly challenged. The Supreme Court's "abortion funding cases" *Beal v. Doe*,⁵¹ *Maher v. Roe*,⁵² and *Harris v. McRae*⁵³ were decided from 1977–80. *Beal* and *Maher* both involved challenges to state Medi-

⁴⁶ JAFFE ET AL., *supra* note 1, at 128. Although the Hyde Amendment passed in 1976, it was enjoined until 1977. *Id.* at 129.

⁴⁷ *Id.* at 127 (quoting Representative Henry Hyde). During the debate, Hyde made his intention to use Medicaid funding to prevent women from choosing abortions and his indifference to the plight of poor women clear, stating "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." *Id.*

⁴⁸ *Id.* at 128 (quoting Representative Daniel J. Flood of Pennsylvania).

⁴⁹ *Id.* at 132. From 1973–75 prior to the Hyde Amendment, thirteen states instituted restrictions on Medicaid abortion funding; federal courts threw out most of these restrictions. *Id.* By the end of 1979, forty states had moved to restrict Medicaid funding. *Id.*

⁵⁰ *Harris v. McRae*, 448 U.S. 297, 302 (1980). Since 1976, Congress has passed the Hyde Amendment every year as an appropriations rider or by joint resolution. *Id.*

⁵¹ *Beal v. Doe*, 432 U.S. 438 (1977).

⁵² *Maher v. Roe*, 432 U.S. 464 (1977).

⁵³ *Harris*, 448 U.S. 297.

caid laws that prohibited coverage for an abortion unless it was necessary to preserve a woman's health. *Harris* challenged the Hyde Amendment. As described in the next section, in the three cases the Supreme Court rejected statutory challenges and constitutional arguments that the funding restrictions were unconstitutional.

After getting the green light from the Supreme Court in *Harris*, the federal government began to extend similar abortion restrictions to other groups that rely on the federal government for health coverage.⁵⁴ New restrictions that expanded the use of government funding as a tool to discourage abortion beyond women who rely on the government for health care coverage were also introduced. Although these restrictions, which included prohibitions on the use of government facilities to perform abortions and restrictions on the activities of programs that received federal funds, created obstacles that were distinguishable from government refusal to fund abortions, the Supreme Court extended the line of the abortion funding cases to find such restrictions constitutional as well.⁵⁵

A. *Medicaid Exclusion of Non-Medically Necessary Abortions*

In 1977, the Supreme Court decided two cases involving state laws prohibiting Medicaid coverage for non-medically necessary abortions. *Beal v. Doe* challenged a Pennsylvania regulation requiring that three doctors certify that an abortion was medically necessary in order for a Medicaid recipient to receive coverage.⁵⁶ *Maher v. Roe* challenged a Connecticut regulation that limited Medicaid coverage to "medically necessary" abortions by requiring a certificate of medical necessity from the attending physician.⁵⁷ The Supreme Court considered and rejected statutory arguments in *Beal*⁵⁸ and held that the restrictions were not unconstitutional in *Maher*.

In *Beal*, the Supreme Court rejected the plaintiffs' argument that the Pennsylvania regulation was inconsistent with the purpose of Title XIX.⁵⁹ Because the regulation only prohibited non-therapeutic abortions, the Court wrote, "[I]t is hardly inconsistent with the objectives of the Act for a State to refuse to fund unnecessary

⁵⁴ See *infra* Part II.C.

⁵⁵ See *infra* Part II.A-C.

⁵⁶ *Beal*, 432 U.S. 438.

⁵⁷ *Maher*, 432 U.S. at 466.

⁵⁸ *Beal*, 432 U.S. at 443. The Third Circuit struck down the regulation on statutory grounds and did not reach the plaintiffs' constitutional arguments. *Id.*

⁵⁹ *Id.* at 444.

though perhaps desirable medical services.”⁶⁰ The Court specifically distinguished the non-therapeutic abortions barred by the regulations from medically necessary abortions.⁶¹ The Court wrote that “serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage.”⁶²

In *Maher v. Roe*, the Supreme Court rejected constitutional challenges to the Connecticut regulation. The Court avoided applying strict scrutiny to the regulation by declining to construe the discriminatory funding scheme as state interference with a woman’s constitutional rights. The Court’s analysis began by distinguishing the funding scheme from abortion restrictions that were struck down in its earlier cases. The Court noted that *Roe* involved a criminal restriction on abortion and that other impermissible restrictions, such as a spousal consent law that imposed an “absolute obstacle to a woman’s decision,” were “different in form but similar in effect.”⁶³

The Court distinguished the funding scheme from prior impermissible obstacles. In fact, it found that the scheme did not create any new obstacle for a poor woman who seeks an abortion. Based on the assertion that “[t]he Constitution imposes no obligation on the States to pay the pregnancy-related medical expenses of indigent women, or indeed to pay any of the medical expenses of indigents,”⁶⁴ it held that

The Connecticut regulation . . . is different in kind from the laws invalidated in our previous abortion decisions. The . . . regulation places no obstacles absolute or otherwise in the pregnant woman’s path to an abortion. An indigent woman who desires an abortion suffers no disadvantage as a consequence of Connecticut’s decision to fund childbirth; she continues as

⁶⁰ *Id.* at 444–45.

⁶¹ *Id.* at 449 (Brennan, J., dissenting). While it is important to distinguish between therapeutic abortions—abortions that are required because pregnancy risks a woman’s health—and non-therapeutic abortions, Justice Brennan argued in dissent that all abortions are medically necessary. He wrote: “Pregnancy is unquestionably a condition requiring medical services Treatment for the condition may involve medical procedures for its termination, or medical procedures to bring the pregnancy to term, resulting in a live birth [A]bortion and childbirth, when stripped of the sensitive moral arguments surrounding the abortion controversy, are simply two alternative medical methods of dealing with pregnancy” *Id.*

⁶² *Id.* at 444.

⁶³ *Maher v. Roe*, 432 U.S. 464, 473 (1977).

⁶⁴ *Id.* at 469. The Court claimed to recognize the “plight of an indigent women who desires an abortion” but suggested that constitutional protections cannot be accorded for “every social and economic ill.” *Id.* at 479.

before to be dependent on private sources for the service she desires.⁶⁵

In addition to holding that the funding scheme did not pose an obstacle to a poor woman seeking an abortion, the Court also suggested that it was within the state's legislative power to adopt policies and allocate public funds in order to influence women's decision-making. The Court wrote that

[t]here is a basic difference between direct state interference with a protected activity and state encouragement of an alternative activity consonant with legislative policy. Constitutional concerns are greatest when the State attempts to impose its will by force of law; the State's power to encourage actions deemed to be in the public interest is necessarily far broader.⁶⁶

The Court's conclusion that the state should be given more leeway when it is affirmatively allocating resources as part of a government policy appears driven by institutional concerns⁶⁷ rather than by an analysis of the impact on a woman's constitutional rights. The Court wrote that the state should be given "wider latitude in choosing among competing demands for limited public funds,"⁶⁸ and that the decision to expend state funds for non-medically necessary abortions "is fraught with judgments of policy and value." In such situations, "the appropriate forum for their resolution in a democracy is the legislature."⁶⁹

B. Medicaid Exclusion of Medically Necessary Abortions: Harris v. McRae

Although *Beal* suggested that there were serious questions about whether denial of coverage for medically necessary abortions violated the purpose of Medicaid, the *Harris* majority sidestepped any substantive discussion of the propriety of denying coverage for a medically necessary service under a program designed to provide health services for the poor. Because the government has no obligation to fund health care for the poor, the Court took the position that the scope of states' obligation to fund medically necessary services was defined by Congress and that Congress did not intend Title XIX to require states to fund any service for which the federal

⁶⁵ *Id.* at 474.

⁶⁶ *Id.* at 475–76.

⁶⁷ See Soohoo & Goldberg, *supra* note 36, at 1008 (discussing legitimacy and competency concerns that have led courts to refrain from enforcing socio-economic rights that require judicial oversight of policy decisions).

⁶⁸ *Maier*, 432 U.S. at 479.

⁶⁹ *Id.*

government withheld funding.⁷⁰ After rejecting plaintiffs' statutory arguments, the Court relied on the distinction drawn between affirmative obligations and government-imposed obstacles in *Maher* to reject plaintiffs' constitutional claims.

The Court defined the liberty interest established by *Roe* as a negative right⁷¹ to "protection against unwarranted government interference . . . in the context of certain personal decisions."⁷² It explicitly rejected the idea that the state had any obligation to ensure that a woman be able to exercise her constitutional right to abortion. It wrote "it simply does not follow that a woman's freedom of choice carries with it a constitutional entitlement to the financial resource to avail herself of the full range of protected choices."⁷³

Although the government's decision to fund all medical care (including pre-natal care) other than medically necessary abortions might impact a poor woman's decision-making, the Court held the government's actions did not merit heightened scrutiny because it identified poverty as the obstacle to her constitutional right to decide to have an abortion rather than the discriminatory funding scheme:

[A]lthough government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation. Indigency falls in the latter category. The financial constraints that restrict an indigent woman's ability to enjoy the full range of constitutionally protected freedom of choice are the product not of governmental restrictions on access to abortions, but rather of her indigency. Although Congress has opted to subsidize medically necessary services generally, but not certain medically necessary abortions, . . . the Hyde Amendment leaves an indigent woman with at least the same range of choice in deciding whether to obtain a medically necessary abortion as she would have had if Congress had chosen to subsidize no health care costs at all.⁷⁴

Although the Court relied heavily on the distinction between state action and inaction, it acknowledged that the plaintiffs' claim was not merely a claim that the state failed to fund a benefit. Congress' refusal to fund medically necessary abortions was not driven by a lack of resources or difficult choices about how to allocate

⁷⁰ *Harris v. McRae*, 448 U.S. 297, 309-10 (1980).

⁷¹ *See* Ginsburg, *supra* note 19, at 384.

⁷² *Harris*, 448 U.S. at 317-18.

⁷³ *Id.* at 316.

⁷⁴ *Id.* at 316-17.

resources amidst conflicting health care priorities. Instead, the Court recognized that the state sought to influence a woman's decision-making process through its selective allocation of resources. Citing *Maher*, the Court again asserted that Congress is entitled to a degree of deference in making funding determinations.⁷⁵ The Court wrote that the constitutional freedom recognized in *Roe v. Wade* "did not prevent [the state] from making 'a value judgment favoring childbirth over abortion, and . . . implement[ing] that judgment by the allocation of public funds.'" ⁷⁶

Based on its distinction between state imposed barriers and funding allocations, the Court rejected the plaintiffs' due process and equal protection claims. Specifically the Court held that "the Hyde Amendment does not impinge on the due process liberty recognized in *Wade*."⁷⁷ It also held that the plaintiffs' equal protection claim was not entitled to strict scrutiny because it did not impinge upon a right or liberty protected by the Constitution⁷⁸ or involve a constitutionally suspect classification.⁷⁹

C. *Extensions of Government Funding Restrictions Beyond Medicaid Recipients*

Following *Maher* and *Harris*, federal and state governments expanded the use of government funding programs to restrict access to abortion services. The first step was the extension of Hyde restrictions beyond poor women to other groups that rely on the federal government for health care coverage. In 1979, abortion coverage restrictions were introduced for military personnel and their dependents and for Peace Corps volunteers.⁸⁰ In the 1980s, restrictions were put in place for women in prisons, federal employees and their dependents, and individuals who rely on Indian Health Services for health care coverage.⁸¹

⁷⁵ *Id.* at 318. The Court wrote that the decision of whether or not to provide funding for abortions is a political decision, which is "a question for Congress to answer, not a matter of constitutional entitlement."

Id.

⁷⁶ *Id.* at 314 (citing *Maher v. Roe*, 432 U.S. 464, 474 (1977)).

⁷⁷ *Harris*, 448 U.S. at 318.

⁷⁸ *Id.* at 322.

⁷⁹ *Id.*

⁸⁰ Boonstra, *supra* note 5. There are no exceptions for the ban on abortion coverage for Peace Corps volunteers. *Id.*

⁸¹ *Id.*; INDIAN HEALTH SERV., DEPT. OF HEALTH & HUMAN SERVS., SGM 96-01, CURRENT RESTRICTIONS ON USE OF INDIAN HEALTH SERVICE FUNDS FOR ABORTIONS (1996), available at http://www.ihs.gov/ihs/index.cfm?module=dsp_ihm_sgm_main&sgm=ihs_sgm_9601.

Legislation was also introduced that attached restrictions on abortion-related activities at government facilities and on entities receiving funding. These restrictions went beyond limiting the range of health services provided to Medicaid recipients and other groups receiving government health care coverage to limit the abortion-related activities of public employees and individuals employed by programs that received federal funds. They also introduced significant practical obstacles in the path of women seeking information or access to abortion services beyond the issue of funding. In *Webster v. Reproductive Health Servs.*, the Supreme Court upheld a Missouri law prohibiting abortion care at public hospitals and prohibiting public employees from performing abortions, even if the patient paid for the services.⁸² In *Rust v. Sullivan*,⁸³ the Supreme Court approved restrictions prohibiting any recipient of Title X family planning funding from engaging in abortion counseling, referral, or advocacy.

Relying on *Maher*, in *Webster* and *Rust*⁸⁴ the Supreme Court rejected the claim that “unequal subsidization” violated the Constitution,⁸⁵ finding instead that the government can “make a value judgment favoring childbirth over abortion, and . . . implement that judgment by the allocation of public funds.”⁸⁶ The Court reaffirmed that the government can “selectively fund a program” that it believes is in the public interest without funding an alternate program.⁸⁷ The Court wrote, “Within far broader limits than petitioners are willing to concede, when the Government appropriates public funds to establish a program it is entitled to define the limits of that program.”⁸⁸ The decisions also invoked *McRae*’s distinction between positive and negative obligations,⁸⁹ stating that refusal to fund a protected activity “cannot be equated with the imposition of a ‘penalty’ on the substantive right.”⁹⁰

⁸² *Webster v. Reprod. Health Servs.*, 492 U.S. 490, 501 (1989).

⁸³ *Rust v. Sullivan*, 500 U.S. 173 (1991).

⁸⁴ *Id.* In *Rust*, the Court also rejected arguments that Title X recipients’ free speech rights were violated based on a similar distinction between “selective funding” and a government penalty. *Id.*

⁸⁵ *Rust*, 500 U.S. at 192–93; *Webster*, 492 U.S. at 507–08.

⁸⁶ *Rust*, 500 U.S. at 192–93 (citing *Maher v. Roe*, 432 U.S. 464, 474 (1977)).

⁸⁷ *Id.* at 193.

⁸⁸ *Id.* at 194.

⁸⁹ *Id.* at 201. Because the government has “no constitutional duty to subsidize a[] . . . constitutionally protected [activity]” it may adopt a legislative policy to fund childbirth and not abortion and “implement that judgment by the allocation of public funds.” *Rust*, 500 U.S. at 201 (citing *Webster*, 492 U.S. at 510).

⁹⁰ *Rust*, 500 U.S. at 193 (citing *Harris v. McRae*, 448 U.S. 297, 317, n. 19 (1980)); *Webster*, 492 U.S. at 507 (citing *DeShaney v. Winnebago County*, 489 U.S. 189 (1989)).

Just as the Court found that the Hyde Amendment left a poor woman no worse off than if Congress had decided not to subsidize health care for the poor, the Court asserted that the funding restrictions in *Webster* and *Rust* left poor women “no worse off.”⁹¹ In reaching this conclusion, the Court ignored the fact that the restrictions did more than refuse to fund abortion services and would impose significant obstacles in the path of a woman’s decision-making about her reproductive health. In *Rust*, the speech restriction undermined a woman’s ability to freely exercise her reproductive choice by suppressing her ability to receive pertinent information from her health care providers.⁹² The Court rejected this argument asserting that a poor woman was still free to obtain information about abortion-related services outside of the Title X program. In doing so, it refused to take into consideration that a poor woman may not have access to a doctor outside of the Title X program, writing, “But once again, even these Title X clients are in no worse position than if Congress had never enacted Title X.”⁹³ Similarly, in *Webster*, the Supreme Court reversed the Eighth Circuit’s holding that there was a fundamental difference between a prohibition of government funding to pay for abortion services and prohibiting staff physicians from performing abortions at existing public hospitals.⁹⁴ The Eighth Circuit recognized that the distance, cost, and practical issues such as doctors’ privileges to perform services at alternative non-public facilities would narrow or possibly foreclose the availability of abortion care for women.⁹⁵ The Court refused to recognize that the restriction on public facilities and employees

for the proposition that the “Due Process Clauses generally confer no affirmative right to governmental aid, even where such aid may be necessary to secure life, liberty, or property interests of which the government itself may not deprive the individual.”).

⁹¹ *Webster*, 492 U.S. at 509 (“Missouri’s refusal to allow public employees to perform abortions in public hospitals leave a pregnant woman with the same choices as if the State had chosen not to operate any public hospitals.”); *Rust*, 500 U.S. at 202 (“The difficulty that a woman encounters when a Title X project does not provide abortion counseling or referral leaves her in no different position than she would have been if the Government had not enacted Title X.”).

⁹² *Rust*, 500 U.S. at 216 (Blackmun, J., dissenting) (“By suppressing medically pertinent information and injecting a restrictive ideological message unrelated to considerations of maternal health, the Government places formidable obstacles in the path of Title X clients’ freedom of choice and thereby violates their Fifth Amendment rights.”).

⁹³ *Rust*, 500 U.S. at 203.

⁹⁴ *Webster*, 492 U.S. at 503.

⁹⁵ *Id.* at 509.

would impose an obstacle meriting serious constitutional consideration.⁹⁶

In addition to impacting women's ability to access abortion services, the Title X restrictions challenged in *Rust* also implicated the free speech rights of the staff and patients of Title X programs because of the prohibitions on abortion counseling, advocacy, and referral. However, the Court rejected First Amendment claims based on the same distinction between the government's decision not to fund a protected activity and government action infringing upon a right.⁹⁷ The Court distinguished *Rust* from cases involving the conditioning of a benefit on the relinquishment of a constitutional right because Title X allowed recipients to engage in abortion advocacy and activities as long as they were kept separate from Title X programming.⁹⁸

D. Criticisms of the Supreme Court Funding Cases

Even before the Supreme Court extended the abortion funding line of cases in *Webster* and *Rust*, there was significant legal and public sentiment that *Maher* and *Harris* had been wrongly decided. After the *Harris* decision, challenges to abortion funding restrictions moved to the state level. Courts in thirteen states—Alaska, Arizona, California, Connecticut, Illinois, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, Oregon, Vermont, and West Virginia—held that their state constitutions required that their state Medicaid programs cover medically necessary abortions even if the federal government would not provide reimbursement for services.⁹⁹ Although the state court decisions accepted the Supreme Court's characterization of the abortion right as a negative

⁹⁶ *Id.* at 510.

⁹⁷ *Rust*, 500 U.S. at 192–93.

⁹⁸ *Id.* at 196–98.

⁹⁹ *State, Dep't. of Health & Soc. Servs. v. Planned Parenthood of Alaska, Inc.*, 28 P.3d 904 (Alaska 2001); *Simat Corp. v. Ariz. Health Care Cost Containment Sys.*, 56 P.3d 28 (Ariz. 2002); *Comm. To Defend Reprod. Rights v. Myers*, 625 P.2d 779 (Cal. 1981); *Doe v. Maher*, 515 A.2d 134 (Conn. Sup. Ct. 1986); *Doe v. Wright*, No. 91-CH-1958, slip op. (Ill. Cir. Ct. Dec. 2, 1994); *Moe v. Sec'y of Admin. & Fin.*, 417 N.E.2d 387 (Mass. 1981); *Women of the State of Minn. by Doe v. Gomez*, 542 N.W.2d 17 (Minn. 1995); *Jeannette R. v. Ellery*, No. BVD-94-811 (Mont. Dist. May 19, 1995); *N.M. Right to Choose/NARAL v. Johnson*, 975 P.2d 841 (N.M. 1998); *Right to Choose v. Byrne*, 450 A.2d 925 (N.J. 1982); *Planned Parenthood Ass'n, Inc. v. Dep't. of Human Res. of State of Or.*, 663 P.2d 1247 (Or. App. 1983), *aff'd on other grounds* 687 P.2d 785 (Ore. 1984); *Doe v. Celani*, No. S81-84CnC, slip op. (Vt. Super. Ct. May 23, 1986); *Women's Health Ctr. of W. Va., Inc. v. Panepinto*, 446 S.E.2d 658 (W. Va. 1993). *See WHOSE CHOICE*, *supra* note 44, at 20-21. An additional four states and the District of Columbia voluntarily opted to cover medically necessary abortions. *Id.*

right to be free from a government-imposed obstacle and rejected any affirmative obligation to ensure that women can access their right to abortion, the state courts held that when the government undertakes to fund a public benefit, it must do so in a neutral way.¹⁰⁰ This neutrality requirement is discussed *infra* in section IV.B.

The approach taken by the state decisions illustrates some of the flaws in the Supreme Court's formalistic distinction between government-imposed obstacles and discriminatory funding programs. The Supreme Court abortion funding cases brushed aside the actual impact the government's policy would have on a poor woman's reproductive health decision-making and options. In contrast, the state decisions examined the restrictions from a poor woman's perspective. The decisions also exhibited a more realistic and contextualized understanding of women's decision-making processes and the impact that the funding restrictions would actually have on women enrolled in Medicaid.¹⁰¹

1. Considering Women's Health Interests

The state decisions placed greater emphasis on the rights and interests impacted by the funding restrictions. The decisions include passages describing why the abortion right was integral to a woman's right to privacy, locating its roots in the right to bodily integrity and the right to make decisions about family life.¹⁰² Un-

¹⁰⁰ The courts took great pains to reject an affirmative obligation to ensure that women can access abortion or other health care related services. *Myers*, 625 P.2d at 871 (“[T]he state has no constitutional obligation to provide medical care to the poor”); *Gomez*, 542 N.W.2d at 28 (noting that plaintiffs’ arguments relied on the fact that differential treatment interfered with women’s decision-making process rather than a state obligation to fund the exercise of every constitutional right); *Panepinto*, 446 S.E.2d at 666 (stating that appellees’ assertion that “the state is not obligated to pay for the exercise of constitutional rights” is true); *Byrne*, 450 A.2d at 935 n.5 (“[T]he right of the individual is freedom from undue government interference, not an assurance of government funding”); *Simat Corp.*, 56 P.3d at 32 (“[W]e do *not* hold that Arizona’s right of privacy entitles citizens to subsidized abortions.”); *Alaska Dep’t of Health*, 28 P.3d at 906 (stating that the issue is “not whether the state is generally obligated to subsidize the exercise of constitutional rights for those who cannot otherwise afford to do so”); *Dep’t of Human Res. of State of Or.*, 663 P.2d at 1255 (“[T]he federally protected right of a woman to choose abortion rather than childbirth is a ‘negative’ right: it prohibits a state from obstructing her exercise of that freedom of choice within the limits of *Roe v. Wade*, . . . but does not require affirmative action by the state to remove obstructions that it did not create.”).

¹⁰¹ Wharton et al., *supra* note 12, at 505.

¹⁰² *Moe*, 417 N.E.2d at 398–99 (stating the right to privacy includes family life and bodily integrity); *Myers*, 625 P.2d at 879 (discussing a woman’s right to “retain personal control over her own body” and her “right to decide for herself whether to

like *Harris*, they also explicitly considered women's health interest in being able to choose and access medically necessary abortions. Some of the decisions identified women's right to health as an additional fundamental interest separate from the privacy right.¹⁰³ Other cases suggested that the right to make personal health care decisions was an element of the right to privacy. Several cases described instances where abortion may be necessary for health reasons and the practical and ethical concerns created by limiting doctors' ability to perform medically necessary abortions and forcing a delay in treatment until a condition becomes life threatening.

The California Supreme Court cited prior cases recognizing that because pregnancy poses health risks, abortion decisions involve "the woman's right[] to life" as well as the right of procreative choice.¹⁰⁴ The court noted that even when a pregnancy is not deemed life threatening, the abortion decision "directly involves the woman's fundamental interest in the preservation of her personal health."¹⁰⁵ The New Jersey Supreme Court considered women's health interest in the balancing test it applied in finding that a funding restriction violated equal protection. The court balanced both "the protection of a woman's health and her fundamental right to privacy against the asserted state interest in protecting potential life."¹⁰⁶ The court appeared to accord significant weight to a woman's health interest because it found that state exclusion of coverage for nontherapeutic abortions, which do not involve the same life or health risks to the mother, was permissible.¹⁰⁷

Consistent with the recognition of women's right to health as an important interest, the state decisions described the myriad situations where continuation of pregnancy may pose health risks but not be deemed necessary to save a woman's life.¹⁰⁸ In such situations, doctors testified that abortion might be the preferred treat-

parent a child."); *Gomez*, 542 N.W.2d at 27 (discussing the right to "integrity of one's own body" and "[t]he right of procreation without state interference").

¹⁰³ *Maher*, 515 A.2d at 150 ("[T]he right to make decisions which are necessary for the preservation and protection of one's own health, if not covered in the realm of privacy, stands in a separate category as a fundamental right protected by the state constitution."); *Byrne*, 450 A.2d at 934, 935 (noting "the high priority accorded by the State to the rights to privacy and health"). See B. Jessie Hill, *Reproductive Rights As Health Care Rights*, 18 COLUM. J. GENDER & L. 501, 507 (2009) (arguing that the notion of the abortion right as part of the negative health care right "unquestionably runs through American abortion jurisprudence").

¹⁰⁴ *Myers*, 625 P.2d at 879 (citing *People v. Belous*, 458 P.2d 194 [Cal. 1969]).

¹⁰⁵ *Id.* at 879.

¹⁰⁶ *Byrne*, 450 A.2d at 937.

¹⁰⁷ *Id.*

¹⁰⁸ *Women of the State of Minn. by Doe v. Gomez*, 542 N.W.2d 17, 24-25 (Minn.

ment to protect the woman's health.¹⁰⁹ Further, during pregnancy, cancer treatment and drug therapies for other conditions and pre-existing diseases normally cannot be provided.¹¹⁰ In such situations, pregnant women who cannot access an abortion "must choose either to seriously endanger their own health by forgoing medication, or to ensure their own safety but endanger the developing fetus by continuing medication."¹¹¹

The decisions also emphasized that the distinction between life and health is arbitrary in practice and "antithetical to the medicine in general."¹¹² The New Jersey Supreme Court noted "the distinction between life and health may be difficult for even the most discerning physician."¹¹³ It emphasized that "[w]hen an abortion is medically necessary is a decision best made by the patient in consultation with her physician without the complication of deciding if that procedure is required to protect her life, but not her health."¹¹⁴ The cases also cited doctors' testimony that health risks associated with abortions increase later in pregnancy and that "postponing an abortion unnecessarily is wholly inconsistent with sound medical practice."¹¹⁵ The decisions described how denial of Medicaid funding placed doctors in the position of being forced to refuse treatment "only to undertake a more complicated and dangerous operation at a later stage when the situation has become life-threatening."¹¹⁶

Recognition that women often need abortions for health reasons led several of the state courts to find that it was improper for state Medicaid programs to single out abortion services for defunding. The Alaska Supreme Court struck down a funding restriction on equal protection grounds holding that "[o]nce the State

1995); *Women's Health Ctr. of W. Va., Inc. v. Panepinto*, 446 S.E.2d 658, 665 (W. Va. 1993); *Maher*, 515 A.2d at 142, 154.

¹⁰⁹ *Moe v. Sec'y of Admin. & Fin.*, 417 N.E.2d 387, 393-94 (Mass. 1981).

¹¹⁰ *Simat Corp. v. Ariz. Health Care Cost Containment Sys.*, 56 P.3d 28, 29-30 (Ariz. 2002) (stating that these conditions include heart disease, diabetes, kidney disease, liver disease, chronic renal failure, asthma, inflammatory bowel disease, gall bladder disease, severe mental illness, hypertension, uterine fibroid tumors, epilepsy, toxemia, and lupus erythematosus). See *State, Dep't. of Health & Soc. Servs. v. Planned Parenthood of Alaska, Inc.*, 28 P.3d 904, 907 (Alaska 2001).

¹¹¹ *Alaska Dep't. of Health*, 28 P.3d at 907.

¹¹² *Moe*, 417 N.E.2d at 393-394; *Maher*, 515 A.2d at 155.

¹¹³ *Right to Choose v. Byrne*, 450 A.2d 925, 935 n.6 (N.J. 1982).

¹¹⁴ *Id.*

¹¹⁵ *Moe*, 417 N.E.2d at 393. See *Byrne*, 450 A.2d at 935, n.6; *Maher*, 515 A.2d at 142, 154-55 (noting that conditions that threaten women's health early in pregnancies can become life threatening as pregnancies progress).

¹¹⁶ *Moe*, 417 N.E.2d at 393.

undertakes to fund medically necessary services for poor Alaskans, it may not selectively exclude from the program women who medically require abortions.”¹¹⁷ Similarly, other state courts found that denial of coverage for medically necessary abortions was inconsistent with the purposes of Medicaid and state commitments to provide for the health of the poor.¹¹⁸

2. Considering the Actual Impact of the Restriction on Poor Women

The state court decisions can also be distinguished from *Harris* based on their consideration of the actual impact of the funding restrictions on the poor women targeted. The courts emphasized the importance of measuring the infringement “in light of the ‘reality of the situation’ . . . and the ‘practical considerations’ of the person the regulation affects.”¹¹⁹ The cases explicitly considered the impact of monetary incentives on poor women and the impact of forcing a woman to obtain funding through other sources.

The courts noted that the funding restrictions created a financial barrier for the very women who could least afford it—poor women who relied on Medicaid for their health care.¹²⁰ “[B]y definition . . . the only women affected by the restrictions at issue are those who lack the money or resources to pay for medically supervised abortion on their own.”¹²¹ The Minnesota Supreme Court wrote that the funding differential between abortion and pregnancy might not interfere with a wealthier woman’s decision-making process, but the impact on a poor woman would be different.

[Faced with disparate funding of abortion and childbearing], financially independent women might not feel particularly compelled to choose either childbirth or abortion based on the monetary incentive alone. Indigent women, on the other hand, are precisely the ones who would be most affected by an offer of

¹¹⁷ *State, Dep’t. of Health & Soc. Servs. v. Planned Parenthood of Alaska, Inc.*, 28 P.3d 904, 906 (Alaska 2001).

¹¹⁸ *Maier*, 515 A.2d at 143 (holding that the regulation was an authorized exercise of authority because Connecticut law and public policy supported paying “all necessary medical expenses for the poor.”); *Women of the State of Minn. by Doe v. Gomez*, 542 N.W.2d 17, 26 (Minn. 1995).

¹¹⁹ *Maier*, 515 A.2d at 153. See also *Alaska Dep’t of Health*, 28 P. 3d at 910 (“[W]e look to the real-world effects of the government action to determine the appropriate level of equal protection scrutiny.”).

¹²⁰ *Comm. to Defend Reprod. Rights v. Myers*, 625 P.2d 779, 793, 796 (Cal. 1981) (“[T]he state has singled out poor women and has subordinated only their constitutional right of procreative choice to the concern for fetal life.”).

¹²¹ *Myers*, 625 P.2d at 793.

monetary assistance, and it is these women who are targeted by the statutory funding ban.¹²²

The California Supreme Court expressed particular concern about the restriction precisely because it targeted the poor.¹²³

Indeed, the statutory scheme . . . is all the more invidious because its practical effect is to deny to poor women the right of choice guaranteed to the rich. An affluent woman who desires to terminate her pregnancy enjoys the full right to obtain a medical abortion By contrast, when the state finances the cost of childbirth, but will not finance the termination of pregnancy, it realistically forces an indigent pregnant woman to choose childbirth even though she had the constitutional right to refuse to do so.¹²⁴

Several of the decisions suggested that the state had an obligation to provide more, not less protection for the rights of the poor women. The Minnesota Supreme Court invoked the state's tradition of "affording persons on the periphery of society a greater measure of government protection and support,"¹²⁵ and expressed special concern about the need to protect the rights of Minnesota's indigent women.¹²⁶

The decisions also considered the alternatives available to poor women denied public funding for therapeutic abortions and the practical effects of forcing women to find other funding sources. The courts noted that women would be forced to delay procedures while they tried to raise medical costs, resulting in later abortions with far greater health risks.¹²⁷ Obtaining funding for a medical procedure outside of the Medicaid scheme also had a punitive impact on women's benefits. The West Virginia and Connecticut courts noted that if a woman received funding to pay for a medical procedure outside of the Medicaid system, the funding must be reported as income which could render the woman ineligible for public benefits or decrease her benefits.¹²⁸

¹²² *Gomez*, 542 N.W.2d at 31. *See* *Women's Health Ctr. of W. Va., Inc. v. Panepinto*, 446 S.E.2d 658, 667 (W. Va. 1993) ("[F]or the indigent woman, the state's offer of subsidies for one reproductive option and the imposition of a penalty for the other necessarily influences her federally-protected choice.").

¹²³ *Myers*, 625 P.2d at 796.

¹²⁴ *Id.* at 799.

¹²⁵ *Gomez*, 542 N.W.2d at 30; *Doe v. Maher*, 515 A.2d 134, 152 (Conn. Sup. Ct. 1986) (noting Connecticut's long history and tradition of health care for the poor).

¹²⁶ *Gomez*, 542 N.W.2d at 31.

¹²⁷ *State, Dep't. of Health & Soc. Servs. v. Planned Parenthood of Alaska, Inc.*, 28 P.3d 904, 907 (Alaska 2001); *Gomez*, 542 N.W.2d at 26.

¹²⁸ *Women's Health Ctr. of W. Va., Inc. v. Panepinto*, 446 S.E.2d 658, 664–65 (W. Va. 1993); *Maher*, 515 A.2d at 154.

III. WHERE WE ARE NOW: THE PRIVATIZATION OF HYDE

After the federal government extended Hyde restrictions to all women who relied on the federal government for health care and the state abortion funding cases were litigated, an uneasy status quo emerged around health care funding for abortion services, with the federal government and the majority of states prohibiting public funding, except in cases of life endangerment, rape, and incest, and a minority of states funding medically necessary abortions. At the same time, while the majority of women with government health care were denied coverage for medically necessary abortions, most women with private health care insurance had abortion coverage.¹²⁹ This state of affairs was disrupted when federal health care reform started to blur the lines between public and private health care.

Although the Patient Protection and Affordable Care Act (“ACA”)¹³⁰ did not prohibit abortion coverage, the debate around the ACA¹³¹ and the compromise crafted by Congress and the Obama administration resulted in setbacks for both the public dialogue and legal landscape around health care coverage for abortion care. The administration’s failure to challenge the current Hyde restrictions on federal funding further entrenched the provisions as a reasonable compromise position and the status quo.¹³² Not only was there a failure to articulate why a government health care policy that excluded coverage for a medically necessary procedure might be problematic, but the debate also failed to question whether it is appropriate for the government to use a public benefit program to coerce poor women’s choices about their health care and reproductive decision-making.

The failure to revisit the Hyde Amendment itself continues to

¹²⁹ *Abortion Care Coverage and Health Care Reform: Getting the Facts Straight*, PLANNED PARENTHOOD, (July 27, 2009), <http://www.plannedparenthood.org/about-us/news-room/press-releases/abortion-care-coverage-health-care-reform-getting-facts-straight-29733.htm> (stating that the “majority of private insurance plans today cover abortion care”).

¹³⁰ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

¹³¹ Jennifer Keighley, *Health Care Reform and Reproductive Rights: Sex Equality Arguments for Abortion Coverage in a National Plan*, 33 HARV. J. L. & GENDER 357, 357 n.7, 359, 369–70 (2010).

¹³² See Exec. Order No. 13,535 § 1, 75 Fed. Reg. 15,599 (Mar. 29, 2010) (“Following the recent enactment of the [ACA], it is necessary to establish an adequate enforcement mechanism to ensure that Federal funds are not used for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered), consistent with a longstanding Federal statutory restriction that is commonly known as the Hyde Amendment.”).

have significant consequences on women who rely on government health care. The number of individuals impacted by the Hyde Amendment will substantially increase under the ACA's Medicaid expansion. Although *Nat'l Federation of Independent Business v. Sebelius* gives states the option of participating in Medicaid expansion,¹³³ the Congressional Budget Office estimates that Medicaid and CHIP will cover an additional eleven million people by 2022.¹³⁴

Under the ACA, a projected twenty-five million Americans will obtain health insurance through newly created state health insurance exchanges.¹³⁵ Low and modest income individuals who buy insurance through the exchanges will receive tax credits and cost-sharing payment reductions.¹³⁶ Rather than rejecting the Hyde Amendment, both the ACA and an implementing Executive Order issued by President Obama parrot the amendment's funding restrictions and apply them to insurance policies offered on the insurance exchanges.¹³⁷ In doing so, the ACA and Executive Order suggest that tax credits and cost-sharing reduction payments for insurance plans that cover abortion care are akin to federal funding of abortion.¹³⁸ To avoid the possible use of federal funds to subsidize premium payments for a plan covering abortion services outside of the Hyde exceptions, the ACA requires that insurers segregate federal funds in a separate account that cannot be used to pay abortion benefits outside of the exceptions.¹³⁹ These segregation requirements may make the defeat of attempts to ban abortion coverage in exchange insurance policies a Pyrrhic victory. The

¹³³ *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

¹³⁴ CBO, *supra* note 3, Table 1. Federal law prohibits the use of federal Medicaid and CHIP funds for abortions except in the case of life endangerment, rape or incest, but states have the authority to use their own funds to cover abortion in a broader range of circumstances. CTR. FOR AM. PROGRESS, *supra* note 5, at 8.

¹³⁵ CBO, *supra* note 3, Table 1. The number of individuals obtaining coverage on the exchanges is estimated to be nine million in 2014 and twenty-five million by 2022. *Id.*

¹³⁶ HENRY J. KAISER FAMILY FOUND., EXPLAINING HEALTH CARE REFORM: QUESTIONS ABOUT HEALTH INSURANCE SUBSIDIES 1 (2012), *available at* <http://www.kff.org/healthreform/upload/7962-02.pdf>.

¹³⁷ Exec. Order No. 13,535 § 1, 75 Fed. Reg. 15,599 (Mar. 29, 2010); 42 U.S.C. § 18023(b)(1)(B) (2010). The ACA distinguishes between "abortions for which public funding is allowed" and "abortions for which public funding is prohibited" and tracks federal law by basing the definitions of these terms on whether the Department of Health and Human Services may expend federal funds on them or not. *Id.*

¹³⁸ Exec. Order No. 13,535, at § 2, 75 Fed. Reg. 15,599 (Mar. 29, 2010); 42 U.S.C. § 18023(b)(2) (2010).

¹³⁹ HENRY J. KAISER FAMILY FOUND., ACCESS TO ABORTION COVERAGE AND HEALTH REFORM 3 (2010), *available at* <http://www.kff.org/healthreform/upload/8021.pdf>.

coverage restrictions are so stringent that leading insurance experts have suggested that most insurers will simply decline to sell policies covering abortion care on the exchanges—and eventually in the broader private market as well.¹⁴⁰

Although the ACA technically allows abortion coverage in exchange policies, the fight has now moved to the state level. The ACA requires that states create insurance exchanges by 2014, and states are beginning to hammer out what the exchanges will look like. Energized by the federal debate around abortion coverage, state legislators have not only passed laws prohibiting insurance policies on state exchanges from covering abortion care, they have also passed legislation prohibiting all private health insurance policies from covering abortion.¹⁴¹ State legislators have also expanded the concept of public funding to look not just at whether the state is paying health care costs for individual women seeking abortions, but also to whether it funds entities that may provide or refer to abortion services, even if state dollars are not used to pay for the services.

A. *The New State Landscape*

Prior to the passage of the ACA, only five states banned insurance coverage for abortion care.¹⁴² Just over two years after the ACA was signed into law, more than a third of states have passed laws to ban abortion coverage on their health care exchanges. As of June 2012, eighteen states—Alabama, Arizona, Florida, Idaho, Indiana, Kansas, Louisiana, Mississippi, Missouri, Nebraska, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Wisconsin, and Virginia—passed legislation prohibiting insurers from

¹⁴⁰ Gold, *supra* note 7, at 9.

¹⁴¹ Jacqueline R. Thomas, *Abortion to be Considered an Essential Benefit*, CONN. MIRROR, June 8, 2012, <http://www.ctmirror.org/story/16602/abortion-be-considered-essential-health-benefit>. At least one state has imposed restrictions in the other direction. Connecticut has found that abortion is an essential benefit that must be covered by insurance policies offered on its exchange. *Id.*

¹⁴² The states were Idaho, Kentucky, Missouri, North Dakota, and Oklahoma. See IDAHO CODE ANN. § 41-2210A (2012); KY. REV. STAT. ANN. § 304.5-160 (West 2012); MO. ANN. STAT. § 376.805 (West 2010) (amended 2010 Mo. Legis. Serv. S.B. 793 (West)); N.D. CENT. CODE ANN. §14-02.3-03 (West 2011); OKLA. STAT. ANN. tit. 63, § 1-1-741.2 (West 2012) *repealed by* Laws 2011, c. 92, § 2, eff. Nov. 1, 2011. See Keighley, *supra* note 131, at 367 n.47; Roy G. Spece, Jr., Note, *The Purpose Prong of Casey's Undue Burden Test and Its Impact on the Constitutionality of Abortion Insurance Restrictions in the Affordable Care Act or Its Progeny*, 33 WHITTIER L. REV. 77, 91 (2011); Nat'l Educ. Ass'n of R.I. v. Garrahy, 598 F. Supp. 1374 (D. R.I. 1984), *aff'd* 779 F.2d 790 (1st Cir. 1986). In addition, Rhode Island passed a statute prohibiting abortion coverage, but it was found unconstitutional. *Id.*

covering abortions in exchange policies.¹⁴³ The exact provisions of the restrictions varied, but most allowed exceptions where a woman's life is in danger but not her health.¹⁴⁴ More than half also included exceptions for abortions in instances of rape or incest.¹⁴⁵ Louisiana and Tennessee do not recognize any exceptions.¹⁴⁶ Perhaps more troubling, Kansas, Nebraska, and Utah went beyond plans offered on the exchanges and banned private insurance coverage for abortion services.¹⁴⁷ Some states that have banned the inclusion of abortion services in health insurance policies allow insurers to offer separate riders covering abortion for an additional

¹⁴³ S.B. 10, 2012 Leg., Reg. Sess. (Ala. 2012); ARIZ. REV. STAT. ANN. § 20-121 (2010); H.B. 97, 2011 Leg., Reg. Sess. (FL 2011); S.B. 1115, 61st Leg., Reg. Sess. (Idaho 2011); H.B. 1210, 117th Gen. Assemb. Leg., Reg. Sess. (Ind. 2011); H.B. 2075, 2011-2012 Leg., Reg. Sess. (Kan. 2011); LA. REV. STAT. ANN. § 22:1014 (2011); MISS. CODE ANN. §§ 41-41-97 to 99 (2012); MO. ANN. STAT. § 376.805 (2012); L.B. 22, 102nd Leg., Reg. Sess. (Neb. 2011); H.B. 79, 129th Gen. Assemb., Reg. Sess. (Ohio 2011-2012); OKLA. STAT. ANN. tit. 63 § 1-741.3 (West 2012); S.B. 102, 119th Gen. Assemb., Reg. Sess. (S.C. 2011-2012); H.B. 1185, 2012 Leg., Reg. Sess. (S.D. 2012); TENN. CODE ANN. § 56-26-134 (2012); H.B. 354, 2011 Gen., Reg. Sess. (Utah 2011); S.B. 92, 2011-2012 Leg., Reg. Sess. (Wis. 2011); H.B. 2434, 2011 Gen. Assemb., Reg. Sess. (Va. 2011). Of the fourteen states, three states, Idaho, Missouri, and Oklahoma already had laws prohibiting abortion coverage in general insurance policies. These three states adopted additional legislation specifically prohibiting abortion coverage in policies offered on the exchanges. IDAHO CODE ANN. § 41-2210A (2012); MO. ANN. STAT. § 376.805 (West 2010) (amended 2010 Mo. Legis. Serv. S.B. 793 (West)); OKLA. STAT. ANN. tit. 63, § 1-1-741.3 (West 2012) (amended by 2011 OK S.B. 547 (West)). See CTR. FOR REPROD. RIGHTS, 2011: A LOOK BACK 4, 10, 12, 16 (2011) [hereinafter 2011 LOOK BACK], available at http://reproductiverights.org/sites/ctr.civicactions.net/files/documents/end_of_year_2011_FINAL.pdf. For an in depth discussion of the Louisiana statute see J. Daniel Siefker, Jr., Comment, *Louisiana's Abortion Politics and the Constitution: The Attempt to Regulate Health Insurance Benefits in the Wake of the National Healthcare Reform*, 13 LOY. J. PUB. INT. L. 253 (2011).

¹⁴⁴ GUTTMACHER INST., STATE POLICIES IN BRIEF: RESTRICTING INSURANCE COVERAGE OF ABORTION (2012), available at http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf. Although more restrictive than a general health exception, Arizona, Indiana, and Utah have created exceptions where pregnancy poses a risk of irreversible impairment of a major bodily function. Wisconsin has an exception for serious physical health conditions and South Dakota for a medical emergency. *Id.* See also S.B. 10, 2012 Leg., Reg. Sess. (Ala. 2012); H.B. 1185, 2012 Leg., Reg. Sess. (S.D. 2012).

¹⁴⁵ See *supra* note 143. The states are Alabama, Florida, Idaho, Indiana, Mississippi, Ohio, Virginia, South Carolina, Wisconsin, and Utah. *Id.*

¹⁴⁶ See *supra* note 143.

¹⁴⁷ H.B. 2075, 2011-2012 Leg., Reg. Sess. (Kan. 2011) (prohibiting insurers on the private market from offering abortion coverage except where necessary to save a woman's life, optional riders are available); L.B. 22, 102nd Leg., Reg. Sess. (Neb. 2011) (prohibiting insurers in private market and exchanges from offering coverage for abortion except where necessary to avert a woman's death, riders are available); H.B. 354, 2011 Gen., Reg. Sess. (Utah 2011) (barring coverage except in cases of rape, incest, lethal fetal anomaly, life endangerment or risk of severe injury; no riders allowed); 2011 LOOK BACK, *supra* note 143, at 4, 12, 13, 18; GUTTMACHER INST., *supra* note 144.

cost.¹⁴⁸ However, even if insurance companies are permitted to offer separate riders, there is no guarantee they will offer them or that employers will choose to elect to purchase riders for employer plans.¹⁴⁹ Further, even if the option is available, it is questionable how many women will purchase a separate rider for a single health care service.

Other states are using state funding to restrict abortion services in more creative ways. Arizona prohibited funding of medical training to perform abortions.¹⁵⁰ It also passed a law preventing taxpayers from taking a state charitable deduction for donations to any organization that provides or refers to abortion services or supports any entity that does so.¹⁵¹ In 2011, Ohio passed a budget that prohibits abortions from being performed in public facilities.¹⁵² States also passed laws de-funding Planned Parenthood and other health care providers that perform or advocate for abortion services.¹⁵³ The legislation appeared to be motivated by a desire to punish Planned Parenthood for its involvement in providing abortions.¹⁵⁴ Sponsors also argued that the funding ban was necessary to prevent Planned Parenthood from using state dollars to pay for abortion services even though Planned Parenthood maintained separate projects for abortion care and family planning and did not commingle funds.¹⁵⁵

¹⁴⁸ See, e.g., H.B. 2075, 2011-2012 Leg., Reg. Sess. (Kan. 2011); L.B. 22, 102nd Leg., Reg. Sess. (Neb. 2011).

¹⁴⁹ See, e.g., Memorandum in Support of Plaintiff's Motion for Summary Judgment at 6, *Am. Civil Liberties Union of Kan. & W. Mo. v. Praeger*, 863 F. Supp. 2d 1125 (D. Kan. 2012) (No. 11-2462-JAR-KGG), 2012 WL 2375233 (stating that after the Kansas law passed not all insurance companies offered riders and even where riders are offered in a group plan, it is up to the employer to decide whether to purchase it, not the individual employee).

¹⁵⁰ H.B. 2384, 50th Leg., Reg. Sess. (Ariz. 2011) (prohibiting the use of state funds for medical training for abortion); 2011 LOOK BACK, *supra* note 143, at 8.

¹⁵¹ H.B. 2384, 50th Leg., Reg. Sess. (Ariz. 2011); 2011 LOOK BACK, *supra* note 143, at 8.

¹⁵² H.B. 153, 129th Gen. Assemb., Reg. Sess. (Ohio 2011-2012); *CTR. FOR REPROD. RIGHTS, 2011 MID-YEAR LEGISLATIVE WRAP-UP 21* (2011), available at http://reproductiverights.org/sites/ctr.civicactions.net/files/documents/state_midyr_wrapup_2011_8.10.11.pdf.

¹⁵³ See H.B. 1210, 117th Gen. Assemb. Leg., Reg. Sess. (Ind. 2011); S.B. 7, 82nd Leg., Reg. Sess. (Tex. 2011); 2011 LOOK BACK, *supra* note 143, at 10, 18. Kansas and North Carolina passed 2012 budgets prohibiting Planned Parenthood from receiving state funds. 2011 LOOK BACK, *supra* note 143, at 12, 14. Wisconsin passed a budget prohibiting state funding to Planned Parenthood and other facilities that perform or refer for abortions. *Id.* at 19.

¹⁵⁴ See, e.g., *Planned Parenthood of Cent. N.C. v. Cansler*, 804 F. Supp. 2d 482, 496 (M.D.N.C. 2011).

¹⁵⁵ See, e.g., *Planned Parenthood of Kan. & Mid-Mo. v. Brownback*, 799 F. Supp. 2d

Lawsuits challenging the new funding restrictions have not proceeded past the district court level and so far have met with mixed success. Following the grant of a preliminary injunction, the State of Arizona agreed to permanently enjoin the prohibition on state tax credits for donations to organizations that provide, or refer to organizations that provide, abortions.¹⁵⁶ The funding restrictions targeting Planned Parenthood in Indiana, Kansas, and North Carolina have been enjoined.¹⁵⁷ A fourth funding restriction in Texas was initially enjoined, but the Fifth Circuit lifted the injunction.¹⁵⁸ As discussed *infra*, the sole case challenging a private insurance ban, although still pending, has been less successful. The court denied plaintiffs' motion for a preliminary injunction and the case is still pending. Although bans on insurance coverage on state insurance exchanges will have a significant impact on women's ability to obtain insurance coverage for abortion services, to date, no lawsuits have been filed to challenge the bans, which do not go into effect until 2014.

B. Challenges to Private Insurance Bans

The private insurance bans create an obstacle for women seeking an abortion. They are distinguishable from the Supreme Court's abortion funding cases because they do not involve decisions about the allocation of government funds. Instead, they create an obstacle preventing women from accessing private insurance funding and should be reviewed by courts as a state imposed restriction on access to abortion. As discussed below, the First Circuit came to this conclusion when it reviewed a private insurance ban in the 1986 case *Garrahy v. Calderone*.

Garrahy and the abortion funding cases were decided when the Supreme Court applied the *Roe v. Wade* standard to determine the constitutionality of abortion restrictions. The *Roe* standard's trimester framework prohibited most abortion restrictions during the first trimester and only permitted regulation of abortion proce-

1218, 1224, 1234 (D. Kan. 2011) (The amendment's sponsor stated that it "took all state funding away from Planned Parenthood to ensure that state dollars are not used for abortion services.").

¹⁵⁶ *State Drops Defense of Arizona Law that Would Have Withheld Critical Resources for Women's Health*, AM. CIVIL LIBERTIES UNION OF ARIZ. (Jan. 30, 2012), available at <http://acluaz.org/issues/reproductive-rights/2012-01/1733>.

¹⁵⁷ *Cansler*, 804 F. Supp. 2d 482; *Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't. of Health*, 794 F. Supp. 2d 892, 905-909, 911 (S.D. Ind. 2011); *Brownback*, 799 F. Supp. 2d 1218.

¹⁵⁸ *Planned Parenthood Ass'n of Hidalgo Cnty. Tex., Inc. v. Suehs*, 828 F. Supp. 2d 872 (W.D. Tex. 2012) *vacated and remanded*, 692 F.3d 343 (5th Cir. 2012).

dures during the second trimester in ways that were reasonably related to the promotion of maternal health.¹⁵⁹ The abortion funding cases avoided review under *Roe's* strict standard by distinguishing government funding decisions from government-imposed restrictions.¹⁶⁰ Because the *Garrahy* court held that a private insurance ban is a government restriction, it applied the *Roe* standard and held the ban unconstitutional. However, in 1992 the Supreme Court's standard for reviewing abortion restrictions changed when *Planned Parenthood v. Casey* introduced the undue burden standard. This section looks at pre-*Casey* private insurance ban cases, describes how *Casey's* undue burden standard changed the Court's review of government-imposed abortion restrictions, and discusses the first post-*Casey* private insurance ban case.

1. Pre-*Casey* Challenges to Insurance Bans

Private insurance bans have been challenged before with mixed results. In 1986, the First Circuit affirmed a district court decision striking down a Rhode Island private insurance ban. In 1992, the Eighth Circuit reversed a grant of summary judgment in favor of plaintiffs challenging a Missouri ban.

In *National Association of Rhode Island v. Garrahy*,¹⁶¹ the District Court of Rhode Island found that a state law that prohibited abortion coverage in comprehensive health insurance policies, except if the life of the mother was endangered or in instances of rape or incest, was unconstitutional. The court distinguished *Harris* and *Maher* finding that restricting private insurance constituted a government-created obstacle to abortion. While

a state is not constitutionally compelled to pay to remove financial burdens it did not impose, [*Harris* and *Maher*] clearly gave no license to the converse, the idea that government is free to create financial obstacles to abortion.¹⁶²

The district court noted that the *Maher* decision relied heavily on the fact that the women who were denied Medicaid funding could "continue as before to be dependent on private sources."¹⁶³

¹⁵⁹ *Roe v. Wade*, 410 U.S. 113, 164 (1973); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 872 (1992).

¹⁶⁰ See *supra* Part II.A-C.

¹⁶¹ *Nat'l Educ. Ass'n of R.I. v. Garrahy*, 598 F. Supp. 1374 (D. R.I. 1984).

¹⁶² *Id.* at 1384.

¹⁶³ *Id.* (citing *Harris v. McRae*, 448 U.S. 297, 316 (1980)). *Garrahy* cited a Third Circuit decision invalidating a Pennsylvania law that required private insurers to issue policies that exclude abortions and that cost less than policies that include abortions because the "requirement adds an additional barrier to a woman's access to an abortion." *Am. Coll. of Obstetricians & Gynecologists, Pa. Section v. Thornburgh*, 737 F.2d

Deciding the case pre-*Casey*, the court applied strict scrutiny to the provision and found it unconstitutional.¹⁶⁴

Six years later, as the Supreme Court began its retreat from *Roe*, the Eighth Circuit relied on its interpretation of the newly developing “undue burden” standard rather than the abortion funding cases to reverse a district court grant of summary judgment invalidating a private insurance ban. Although *Coe v. Melahn*,¹⁶⁵ was decided before *Casey*, the Eighth Circuit anticipated that the Supreme Court was moving toward upholding restrictions on abortion outside the public funding context. Its decision shifted the inquiry from whether or not the law constituted a government-created obstacle to the weight of the obstacle created. Relying on a non-funding case in which the Supreme Court upheld second trimester abortion restrictions despite the fact that they would cause delay and make abortion services more expensive, the Eighth Circuit held that the insurance ban did not constitute an undue burden and declined to apply strict scrutiny.¹⁶⁶

2. *Casey*'s Undue Burden Standard

In the 1992 case *Planned Parenthood v. Casey*, the Supreme Court articulated a new standard for reviewing abortion restrictions outside of the public funding context that would result in its upholding abortion restrictions that previously had been found unconstitutional under *Roe*. *Casey* held that the government can interfere with women's decision-making process prior to viability as long as it does not impose an undue burden.¹⁶⁷ The Court wrote that:

throughout pregnancy the State may take measures to ensure that the woman's choice is informed, and measures designed to advance this interest will not be invalidated as long as their purpose is to persuade the woman to choose childbirth over abortion. These measures must not be an undue burden on the right.¹⁶⁸

283, 303 (3d Cir. 1984) *aff'd sub nom.* Thornburgh v. Am. Coll. of Obstetricians & Gynecologists, 476 U.S. 747 (1986) *overruled by Casey*, 505 U.S. 833.

¹⁶⁴ *Garrahy*, 598 F. Supp. at 1385 (citing *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 444 n.33 (1983) *overruled by Casey*, 505 U.S. 833). Under the *Roe* standard, the court held that “any statute, other than a ‘governmental spending statute,’ . . . that adds cost and delay to the abortion procedure will not survive if it has any significant impact on the abortion right, unless justified by a compelling state interest.” *Id.* at 1383–84.

¹⁶⁵ *Coe v. Melahn*, 958 F.2d 223 (8th Cir. 1992).

¹⁶⁶ *Id.* at 225–226.

¹⁶⁷ *Casey*, 505 U.S. at 873, 875–76.

¹⁶⁸ *Id.* at 878.

The *Casey* decision stated that “an undue burden is a shorthand for the conclusion that a state regulation has the *purpose* or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.”¹⁶⁹ The Court explained that a statute that has the purpose of creating an undue burden is invalid because the means chosen by the state to further its “interest in potential life must be calculated to inform the woman’s free choice, not hinder it.”¹⁷⁰

Although *Casey* suggested that a restriction would be unconstitutional if it had the purpose or effect of creating an undue burden, in practice courts have been reluctant to rely on the improper purpose prong alone as grounds to invalidate a restriction.¹⁷¹ Instead courts either fail to engage in a searching inquiry into legislative purpose¹⁷² or conflate purpose with effect.¹⁷³ The decisions considering whether restrictions were passed with an improper purpose have also been criticized for mechanically holding that restrictions that are similar to those upheld in *Casey* are constitutional without independently considering the legislature’s intent in enacting them. Commentators have suggested that review of a different type of restriction may result in a more searching inquiry.¹⁷⁴ The majority of cases applying the undue burden standard have involved restrictions that arguably seek to achieve a permissible goal, such as “promoting a woman’s informed choice,” but also have the collateral effect of imposing obstacles in the form of delay or expense. The private funding restrictions appear to have no purpose other than to create a financial obstacle in the path of a woman seeking an abortion. Thus, challenges to the private insurance bans will provide courts an opportunity to consider whether laws designed solely to burden access to abortion are constitutional.

3. Private Insurance Bans: *ACLU v. Praeger*

In 2011, the ACLU brought the first post-*Casey* challenge to a

¹⁶⁹ *Id.* at 877 (emphasis added).

¹⁷⁰ *Id.*

¹⁷¹ Wharton et al., *supra* note 12, at 377–85.

¹⁷² *Id.* at 377. *But see* Planned Parenthood of Heartland v. Heineman, 724 F. Supp. 2d 1025, 1044–46 (D. Neb. 2010) (granting a preliminary injunction and holding that the only sensible construction of a statute which imposed informed consent requirements that were impossible or nearly impossible to comply with and placing doctors in immediate danger of crippling litigation was that it was intended to place a “substantial, if not insurmountable, obstacle in the path of any woman seeking an abortion in Nebraska”).

¹⁷³ Wharton et al. *supra* note 12, at 344–45, 377.

¹⁷⁴ *Id.* at 384–85.

private insurance ban. The case challenged a newly enacted Kansas law that prohibited insurance companies from covering abortion services in their comprehensive plans, except in instances when the abortion was necessary to save a woman's life. The complaint alleged due process and equal protection violations, but the ACLU's preliminary injunction motion relied solely on the improper purpose prong of the undue burden standard.¹⁷⁵ The district court denied the motion, though it specifically left the question of whether the law had the effect of creating a substantial obstacle open.¹⁷⁶ The case is still pending.¹⁷⁷

In its opposition to the motion for preliminary injunction, Kansas argued that the private insurance ban should be reviewed under a rational basis standard like the abortion funding cases and the law should be upheld because the state could rationally choose to regulate insurance in a manner that subsidizes normal childbirth but not non-therapeutic abortions.¹⁷⁸ However, the abortion funding cases were premised on the Supreme Court's distinction between a discriminatory benefits program and a government-imposed obstacle. As the *Garrahy* court pointed out, a private insurance ban imposes an obstacle in the path of a woman seeking an abortion. Indeed, the *Maher* decision emphasized that the government's discriminatory benefits program would still leave Medicaid recipients free to obtain funding through private sources.¹⁷⁹ The Kansas law imposes a state obstacle that prevents a woman from obtaining funding from private sources. Although the district court correctly recognized that the undue burden standard applied to the Kansas law, it denied the preliminary injunction motion finding that the ACLU failed to show that the "Kansas legislature's predominant motive . . . was to create a substantial obstacle to abortion."¹⁸⁰ In particular, the court suggested that the state might have a permissible interest in protecting the conscience rights of

¹⁷⁵ *Am. Civil Liberties Union of Kan. & W. Mo. v. Praeger*, 815 F. Supp. 2d 1204, 1210 (D. Kan. 2011). This may be because it was difficult to prove what the effect of the law would be before it went into effect.

¹⁷⁶ *Praeger*, 815 F. Supp. 2d at 1215 ("Whether the practical *effect* of the law is to actually create a substantial obstacle is another question, but plaintiff has not attempted in this motion to put on evidence to establish such an effect, and the court expresses no opinion here on that question.") (emphasis added).

¹⁷⁷ In March 2012, the District Court denied a motion to dismiss the plaintiff's equal protection claim. *Am. Civil Liberties Union of Kansas & W. Mo. v. Praeger*, 863 F. Supp. 2d 1125 (D. Kan. 2012).

¹⁷⁸ Defendant's Response to Plaintiff's Motion for Preliminary Injunction, *Am. Civil Liberties Union of Kansas & W. Mo. v. Praeger*, 863 F. Supp. 2d 1125 (D. Kan. 2012).

¹⁷⁹ *Maher v. Roe*, 432 U.S. 464, 474 (1977).

¹⁸⁰ *Praeger*, 815 F. Supp. 2d at 1214.

individuals who buy health care insurance who may not want their premiums to contribute to risk pools that pay medical providers who perform abortions.

The court's decision reflects a fundamental misunderstanding of the nature of insurance and the relationship between individuals who buy health insurance. Insurance constitutes a contract between the insurer and the insured where the insured pays a premium to the insurer to indemnify him or her against a risk.¹⁸¹ As argued by the ACLU in its subsequent motion for summary judgment,

[t]here is no 'subsidy' by any third party in the contractual agreement between insurer and insured. . . . As in any business enterprise, an insurance company's customers pay for the services they receive, and the company operates on the revenues it receives; neither the insurer nor any insured 'subsidizes' anything in this commercial transaction.¹⁸²

Perhaps more troubling is the state's assertion that the individuals who buy health insurance have a "conscience right" to prevent other individuals from obtaining insurance coverage for abortion care simply because they may use the same insurance company.¹⁸³ The idea that unnamed individuals, who are neither the women receiving abortion care nor the medical professionals providing care, have a conscience right to interfere with others' right to obtain insurance coverage for abortion care would constitute a dramatic and potentially limitless expansion of the concept of conscientious refusal.¹⁸⁴

¹⁸¹ BLACK'S LAW DICTIONARY (9th ed. 2009) (defining insurance as "[a] contract by which one party (the *insurer*) undertakes to indemnify another party (the *insured*) against risk of loss, damage, or liability arising from the occurrence of some specified contingency An insured party usu. pays a premium to the insurer in exchange for the insurer's assumption of the insured's risk.").

¹⁸² Memorandum in Support of Plaintiff's Motion for Summary Judgment, *supra* note 149, at 18–19.

¹⁸³ For a discussion about problems with extending conscientious refusal claims to health care institutions, which are several steps closer to the actual provision of services than health care insurers or individual insurance buyers, see Elizabeth Sepper, *Taking Conscience Seriously*, 98 VA. L. REV. 101 (2012) (introducing a new framework to evaluate conscientious objection claims that negotiates between individual and institutional interests to protect conscience more consistently).

¹⁸⁴ International human rights law recognizes that only medical personnel directly providing abortions have conscience rights and that exercise of their rights cannot compromise the health and reproductive rights of others. See *e.g.*, T-388/09, discussed *infra* note 201; R.R. v. Poland, App. No. 27617/04, 2011 Eur. Ct. H.R. ¶ 206 ("States are obliged to organise their health services in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are

The *Praeger* case is still pending. The ACLU has moved for summary judgment arguing that Kansas has essentially conceded an improper purpose by asserting in its pleadings that it enacted the law to “treat abortion differently than other medical procedures” and to make it more expensive than childbirth.¹⁸⁵ The outcome of the case may ultimately turn on what showing the court requires to establish that the law’s predominant purpose was to impose a substantial obstacle to abortion¹⁸⁶ and whether it accepts the protection of the conscience rights of unnamed anti-choice insurance purchasers to be a valid and plausible alternative government motive.¹⁸⁷ Although the ACLU has strong grounds to assert that the law violates the undue burden standard, the standard itself is problematic because it explicitly allows the government to adopt policies that impose abortion restrictions as long as the plaintiff cannot establish that the law’s purpose or effect is to impose a substantial obstacle. As discussed below, a more rights-protective approach would impose an obligation on the government to adopt policies to ensure that women have access to abortion care rather than delineate the circumstances under which it may adopt policies to undermine access.

IV. WHERE WE COULD BE: ALTERNATIVE WAYS TO LOOK AT HEALTH CARE COVERAGE FOR ABORTION

This section considers three alternative ways to analyze abor-

entitled under applicable legislation.”); Comm. on the Elimination of Discrimination Against Women, General Recommendation No. 24, Article 12 of the Convention (Women and Health) A/54/38/Rev.1, chap. I ¶ 11 (1999), *available at* <http://www.unhcr.org/refworld/docid/453882a73.html> (“[I]f health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.”). See Bernard M. Dickens, *Legal Protection and Limits of Conscientious Objection: When Conscientious Objection is Unethical*, 28 MED. & L. 337 (2009).

¹⁸⁵ Memorandum in Support of Plaintiff’s Motion for Summary Judgment, *supra* note 149, at 13.

¹⁸⁶ The ACLU may also be able to prove that the law has the effect of imposing a substantial obstacle under the other prong of the undue burden test.

¹⁸⁷ Memorandum in Support of Plaintiff’s Motion for Summary Judgment, *supra* note 149, at 11–12. The ACLU argues that the Supreme Court has only recognized three valid state interests for imposing abortion restrictions (1) the state’s interest in potential life, (2) its interest in the “health or safety of a woman seeking an abortion,” and (3) its interest “in protecting the integrity and ethics of the medical profession.” It asserts that the State can only advance its interest in potential life by adopting measures to inform women’s decision-making. *Id.* According to the ACLU, these three interests reflect a careful balancing by the Supreme Court of the interests at stake, and although the Supreme Court has not foreclosed the possibility of additional valid interests, it cannot be that any state interest that would be permissible under a rational basis review would establish a valid purpose in the abortion context. *Id.* at 16.

tion funding restrictions in the public and private context. It first considers the adoption of a concept of reproductive autonomy that includes an affirmative government obligation to take steps to ensure rights. This formulation provides the most robust protection for reproductive rights, but is the furthest from current Supreme Court doctrine. The second section considers the minority view in the United States reflected by the standard adopted by U.S. state court decisions that require Medicaid funding of medically necessary abortions. The “neutrality” standard does not recognize affirmative government obligations, but requires that when the government undertakes programs to fund and provide benefits that it do so in a neutral, non-coercive way. The last section looks at a recent case from the Supreme Court of Canada that suggests that even a negative conception of the rights to liberty and personal security would require that the government refrain from prohibiting private insurance coverage.

A. *Affirmative Obligation: Decisions from the ECHR, Colombia and Nepal*

Although in the U.S. fundamental rights protected by the Constitution are generally conceived as a “negative” freedom from government violation or intervention,¹⁸⁸ there is growing international recognition that respect for civil and political rights may require affirmative government action.¹⁸⁹ Recent cases from the European Court of Human Rights (“ECHR”), the Constitutional Court of Colombia, and the Supreme Court of Nepal recognize that women have a right to access legal abortion care and explore the affirmative government obligations that flow from the right. The ECHR’s decision was based on the right to private life and privacy, while the cases from Colombia and Nepal invoked a broader range of rights including dignity, liberty and autonomy, health, non-discrimination, freedom from cruel, inhuman, and degrading treatment, freedom from sexual violence, and the benefit from scientific progress.¹⁹⁰ The cases go farther than the state

¹⁸⁸ Ginsburg, *supra* note 19, at 384. See Louis Henkin, *Rights: Here and There*, 81 COLUM. L. REV. 1582, 1589 (1981) (discussing that U.S. rights theory is a negative rights theory, explaining that “Congress is not *required* to do *anything* to protect or promote individual rights, or to make them effective, or more effective”) (emphasis added).

¹⁸⁹ See *supra* Part I.B.

¹⁹⁰ *Lakshmi Dhikta v. Nepal*, Supreme Court of Nepal 2009, 6 (unofficial translation on file with author); Emilia Ordolis, *Lessons From Colombia: Abortion Equality and Constitutional Choices*, 20 CANADIAN J. WOMEN & THE L. 263, 265 (2008).

funding decisions discussed *infra* because in addition to requiring that the government refrain from imposing barriers and decriminalize abortion, the cases articulate an affirmative government obligation to take steps to make services accessible.

1. ECHR: *R.R. v. Poland*

In a 2011 case, *R.R. v. Poland*, the European Court of Human Rights held that a woman's right to determine whether to continue a pregnancy falls within the sphere of private life and privacy and that there are "positive obligations inherent in effective 'respect' for private life."¹⁹¹ The ECHR found that if Polish law allows for abortions in cases of fetal abnormality, it must take steps to ensure that the right is not merely theoretical by establishing effective and accessible procedures to ensure that a pregnant woman has access to diagnostic services necessary for her to determine whether fetal abnormalities exist.¹⁹²

2. Colombian Constitutional Court: C-355/06 and T-388/09

While *R.R.* recognized that respect of the right to privacy may entail affirmative government obligations to adopt effective procedures, it did not tackle the more thorny question of whether the government has an obligation to create enabling conditions or ensure that sufficient resources are available so that all women, rich or poor, can access abortion care.¹⁹³ In two recent decisions, the Colombian Constitutional Court held both that women have a constitutional right to access abortion in certain circumstances and that the government has an obligation to take steps to ensure that abortion services are available throughout the country and as part of the public health network. It also emphasized that inability to pay for services should not prevent women from accessing abortion care.

In its landmark case C-355/06, the Colombian Constitutional court struck down parts of a criminal abortion ban, holding that women's fundamental rights limited the legislature's power to criminalize abortion in all circumstances.¹⁹⁴ The court's recogni-

¹⁹¹ *R.R. v. Poland*, App. No. 27617/04, ¶¶ 184, 214 (Eur. Ct. H.R. 2011).

¹⁹² *Id.* ¶¶ 210, 213.

¹⁹³ *Id.* ¶ 198. The ECHR distinguished *R.R.* from cases alleging denial of health services for "reasons of insufficient funding or availability." *Id.*

¹⁹⁴ Corte Constitucional [C.C.][Constitutional Court], mayo 10, 2006, Sentencia C-355/06 (Colom.), available at http://www.unifr.ch/ddp1/derechopenal/jurisprudencia/j_20080616_03.pdf (in Spanish). Excerpts from C-355/06 are available at

tion of women's sexual and reproductive rights was strongly influenced by international human rights law, which forms part of the "constitutional block or bundle" that guides the Constitutional Court's decisions.¹⁹⁵ The decision extensively discussed international human rights standards concluding that "women's sexual and reproductive rights have finally been recognized as human rights and, as such, they have become part of constitutional rights."¹⁹⁶ Applying a proportionality analysis, the court held that the criminal abortion ban impermissibly infringed on women's right to dignity, autonomy, life, health, and personal integrity because it lacked exceptions for instances where the woman's life or health was at risk, where pregnancy results from rape or incest, and where the fetus has malformations incompatible with life outside the womb.¹⁹⁷

The court noted that its decision decriminalized abortion under the three circumstances discussed above without the need for further legislative or regulatory action, but it also noted that women's sexual and reproductive rights imposed an affirmative obligation on the government. The court cited international human rights law standards imposing state duties to "offer a wide range of high quality and accessible health services, which must include sexual and reproductive health services," and to eliminate obstacles that impede women's access to services and education and information.¹⁹⁸ The court invited the legislature and other authorities to "adopt[] decisions within their discretion . . . in order to fulfill their duties with respect to the constitutional rights of women" such as "taking measures that will effectively ensure women access

http://www.womenslinkworldwide.org/pdf_pubs/pub_c3552006.pdf [hereinafter C-355/06 Translation]; Martha F. Davis, *Abortion Access in the Global Marketplace*, 88 N.C. L. REV. 1657, 1679–80 (2010); Ordolis, *supra* note 190, at 265.

¹⁹⁵ The Colombian Constitution explicitly incorporates international human rights treaties ratified by Colombia into its domestic legal system. Article 93 of the Constitution provides that human rights treaties have "priority domestically" and that "[t]he rights and duties mentioned in [the] Charter will be interpreted in accordance with international human rights treaties ratified by Colombia." See Veronica Undurraga & Rebecca Cook, *Constitutional Incorporation of International and Comparative Human Rights Law: The Colombian Constitutional Court Decision C-355/2006* in CONSTITUTING EQUALITY: GENDER EQUALITY AND COMPARATIVE CONSTITUTIONAL LAW 215, 225 (Susan H. Williams, ed. 2009) (explaining the concept of the "constitutional block").

¹⁹⁶ C-355/06 Translation, *supra* note 194, at 31. The court held that "the rights of the pregnant woman [are] protected by the Constitution of 1991 as well as by the international human rights treaties that are part of the *Constitutional Bundle*." C-355/06 Translation at 59.

¹⁹⁷ C-355/06 Translation, *supra* note 194, at 51–57. Undurraga & Cook, *supra* note 195, at 238–39.

¹⁹⁸ C-355/06 Translation, *supra* note 194, at 28–29.

in conditions of equality and safety.”¹⁹⁹ In response to the court’s decision, in December 2006, the Minister of Social Protection issued a regulation, which set out specific measures to ensure access to abortion services including coverage of legal abortions by the public health system.²⁰⁰

In 2009, the Constitutional Court issued a second decision providing more guidance on the government’s obligation to ensure access to abortion in instances where it is constitutionally protected.²⁰¹ Case T-388/09 involved a municipal judge who refused to grant a court order permitting an abortion that was permissible under C-355/06 due to severe fetal abnormalities because of his personal beliefs opposing abortion. In upholding an intermediate court decision overturning the ruling and ordering termination of the pregnancy, the Constitutional Court stressed the gravity and impropriety of the municipal judge’s actions.²⁰² It emphasized that judicial officers have a duty to apply the law and cannot refuse to perform their duties based on personal convictions.²⁰³ The court also stated that conscientious objection is not an absolute right and that it is limited to the extent that it violates the fundamental rights of others, including women’s sexual and reproductive rights.²⁰⁴

The Constitutional Court took the opportunity to reiterate the government’s obligation to ensure access to abortion where constitutionally protected under C-355/06. Perhaps in light of challenges women continued to face in accessing abortion care services, the court described the scope of the government’s obligation in

¹⁹⁹ *Id.* at 59.

²⁰⁰ GUTTMACHER INST., MAKING ABORTION SERVICES ACCESSIBLE IN THE WAKE OF LEGAL REFORMS: A FRAMEWORK OF SIX CASE STUDIES 22 (2012), available at <http://www.gutmacher.org/pubs/abortion-services-laws.pdf>; Davis, *supra* note 194, at 1681; Ordolis, *supra* note 190, at 275. After the regulation was in force for nearly three years, an anti-abortion coalition challenged the regulation and enforcement was suspended in October 2009 based on a technical argument that the Constitutional Court’s decision should be implemented by the legislature rather than the executive. GUTTMACHER INST., at 24; Davis, *supra* note 194, at 1681 n.130.

²⁰¹ Corte Constitucional [C.C.] [Constitutional Court], mayo 28, 2009 Sentencia T-388/09 (Colom.), available at <http://www.corteconstitucional.gov.co/relatoria/2009/T-388-09.htm> (in Spanish).

²⁰² *Id.* § 7.

²⁰³ *Id.* § 5.3.

²⁰⁴ *Id.* §§ 5.1, 5.2. The court engaged in a lengthy discussion of the scope of the right to conscientious objection and stated that the right (1) is an individual right that does not extend to health care institutions, (2) only applies to medical personnel who are directly involved in the procedure and does not include individuals performing preparatory tasks or providing post-treatment care, and (3) can only be asserted by medical personnel where there is a guarantee that the woman can still access quality and safe care without additional barriers. *Id.*

greater detail. It stated that (1) women should have access to information about their rights and the court's decisions, (2) abortion services should be available throughout the country at all levels of care and sufficiently available in the public health network, and (3) a woman cannot be denied access to constitutionally protected abortion care because she does not have insurance or the ability to pay for services.²⁰⁵ It also emphasized that obstacles or barriers to constitutionally protected abortions are categorically prohibited.²⁰⁶

As part of its decision, the Constitutional Court ordered the Ministries of Social Welfare and Education and the Attorney General and Public Defender to design and implement campaigns to promote sexual and reproductive rights and increase awareness of the court's decisions. The court urged the government to monitor the campaigns to assess their impact and effectiveness.²⁰⁷ It also ordered the National Superintendent of Health to adopt measures requiring that the entities that promote and provide health care (whether public or private, secular or religious) employ enough medical professionals to provide constitutionally protected abortions and abstain from imposing impermissible requirements on abortion access.²⁰⁸

3. Nepal Supreme Court: *Dhikta v. Nepal*

The Colombian Constitutional Court decisions provide greater specificity about the scope of government affirmative obligations to ensure access to abortion where constitutionally protected, requiring that the government affirmatively inform women about their rights, ensure that adequate service providers are available, and prohibit health care institutions from imposing barriers to abortion access. The decisions also articulate a principle that services should be available on a basis of equality and should not be denied for lack of ability to pay. In the 2009 decision *Lakshmi Dhikta v. Nepal*, the Supreme Court of Nepal imposed similar obligations to make information available and expand the availability of service providers. Further, in addition to articulating the principle that services should be equally accessible, it articulates a government obligation to ensure that services are affordable.

In 2002, Lakshmi Dhikta sued the Nepalese government after she was forced to continue an unwanted pregnancy and give birth

²⁰⁵ *Id.* § 4.4(ii), (iii), (vi), (vii).

²⁰⁶ *Id.* § 4.4 (viii).

²⁰⁷ *Id.* at Third, 22.

²⁰⁸ *Id.* at Fourth, 22.

to a sixth child because she could not afford an abortion at a government health facility.²⁰⁹ The *Dhikta* case required the Nepalese Supreme Court to consider the scope of a woman's right to abortion following the 2002 decriminalization of abortion and the adoption of a provision in the Interim Constitution recognizing that "every woman shall have the right to reproductive health and rights relating to reproduction."²¹⁰ In its decision, the court affirmed that abortion is an important part of women's reproductive rights and recognized that reproductive health and rights are integral to women's human rights to dignity, liberty and autonomy, health, privacy, non-discrimination, freedom from cruel, inhuman, and degrading treatment, freedom from sexual violence, and the benefit from scientific progress.²¹¹

The Nepalese Supreme Court articulated a robust conception of the fundamental rights protected by its constitution and an affirmative government obligation to ensure them. The court stated that it is insufficient for fundamental rights to be merely declaratory. Instead, people must be able to benefit from the rights in practice.²¹² The court infused its conception of rights with a strong equality principle, asserting that rights cannot be confined to a particular class but rather must be equally enjoyed by all.²¹³ The court also articulated a commitment to ensuring access to abortion care for poor and rural women.²¹⁴

On the issue of affordability, the court emphasized that the government had an obligation to ensure that no woman is denied a legal abortion because she cannot pay for it.²¹⁵ It stated that the government should monitor the fees charged for abortion care and set limits to ensure that fees charged take into account women's ability to pay.²¹⁶ It also instructed the government to consider providing free services for women who cannot afford to

²⁰⁹ Melissa Upreti, *Nepal Advances As U.S. Backslides on Women's Rights*, RH REALITY CHECK (Mar. 1, 2011, 6:49 PM) <http://www.rhrealitycheck.org/blog/2011/03/01/nepal-takes-huge-step-women-rights-while-backslides>.

²¹⁰ INTERIM CONST. OF NEPAL 2063 (2007) § 20(2), Jan. 15, 2007, *available at* <http://www.unhcr.org/refworld/docid/46badd3b2.html>; Upreti, *supra* note 209.

²¹¹ *Lakshmi Dhikta v. Nepal*, Supreme Court of Nepal 2009, 6 (unofficial translation on file with author).

²¹² *Id.* at 22.

²¹³ *Id.* at 22, 23, 25, 26.

²¹⁴ *Id.* at 23, 24.

²¹⁵ CTR. FOR REPROD. RIGHTS, LAKSHMI DHIKTA V. NEPAL FACT SHEET, *available at* <http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Lakshmi%20Dhikta%20Factsheet%20FINAL.PDF>; Upreti, *supra* note 209.

²¹⁶ *Dhikta* at 24–26.

pay.²¹⁷

A constitutional vision that focuses on whether people can enjoy rights in practice requires more than “non-interference.” It imposes a government obligation to develop and adopt policies to ensure rights. Consistent with high court decisions from other countries,²¹⁸ the court recognized its responsibility to ensure that constitutional rights were both observed and implemented,²¹⁹ but emphasized that it is the government’s responsibility to establish specific laws and policies to realize the rights.²²⁰ However, in addition to generally noting a government obligation to establish infrastructure and monitoring procedures, the court highlighted specific issues for the government to address, including providing information about the decriminalization of abortion and the procedures to obtain services,²²¹ increasing the number of health workers and expanding their presence throughout the country,²²² and taking measures to ensure that fees charged are reasonable given women’s ability to pay, including setting fair rates.²²³ As a general principle, the court stated that government policies should distribute services according to the needs of the people.²²⁴ It emphasized the government’s efforts would be evaluated by whether the individuals who need services are actually able to access them.²²⁵

4. Affirmative Obligations to Ensure Access to Abortion

The ECHR, Colombian, and Nepalese decisions are notable for the courts’ focus on results—whether or not women can exercise their rights—rather than the adequacy or impropriety of government actions. Like the state abortion funding cases, the courts’ analysis is more contextual and less formalistic, focusing on the actual experience of women seeking services.²²⁶ The Colombian and Nepalese courts also articulate a commitment to equality in acces-

²¹⁷ *Id.* at 23–25.

²¹⁸ See Soohoo & Goldberg, *supra* note 36, at 1030–32 (describing cases where in the absence of bad faith, courts may issue declarations or recommendations to engage in a dialogic approach, which increases institutional competence, democratic legitimacy, and the likelihood of robust enforcement)

²¹⁹ Dhikta, at 26.

²²⁰ *Id.* at 11–12.

²²¹ *Id.* at 26.

²²² *Id.* at 11–12.

²²³ *Id.* at 22, 23.

²²⁴ *Id.* at 23, 25.

²²⁵ *Id.* at 22–24.

²²⁶ See *supra* Part II.D.2. See C-355/06 Translation, *supra* note 194, at 16–17 (noting that illegal abortion is a serious public health problem that “primarily affects adoles-

sing fundamental rights and to ensuring that all women, rich or poor, have access to services²²⁷ that was notably absent in the Supreme Court's decision in *Harris v. McRae*. *Dhikta* in particular recognizes that the government must address the issue of affordability by setting fees and considering the provision of free services.

Applying *Dhikta* and the Colombian Constitutional Court's reasoning to the right to abortion in the United States would require that the government adopt policies to promote women's ability to access abortion care instead of allowing the government to adopt funding policies designed to discourage abortion. Recognizing an affirmative government obligation would require that government policies take steps to remove affordability as a barrier to access for poor women rather than exploit their inability to afford care through discriminatory health care funding and bans on the provision of abortions in public facilities. Although courts imposing affirmative government obligations to ensure rights have been hesitant to require the adoption of specific policy measures, their review typically will consider whether the government has adopted policies that are reasonably crafted to ensure the protected right²²⁸ and find a violation where policies are designed to frustrate rather than achieve that goal. The European Court of Human Rights has stated that if a state recognizes a legal right to abortion it may not "structure its legal framework in a way that would limit real possibilities to attain it."²²⁹ Applying this standard, discriminatory benefit programs that undermine affordability and laws that impose obstacles to private insurance cannot be viewed as reasonable policies designed to ensure access to abortion. Similarly, reasonable policies to fulfill the government's affirmative obligations would require that the government work to improve access to abortion care at public health facilities rather than prohibit it.

B. *Government Neutrality: State Court Funding Decisions*

R.R., the Colombian Constitutional Court cases, and *Dhikta* provide the most expansive conception of government obligations to ensure reproductive autonomy addressing many of the concerns

cents, displaced victims of internal armed conflict, and those with the lowest levels of education and income").

²²⁷ T-388/09, § 4.4(ii), (iii), (vii); *Dhikta*, at 22–26.

²²⁸ Soohoo & Goldberg, *supra* note 36, at 1021; *R.R. v. Poland*, App. No. 27617/04, ¶¶ 213, 214 (Eur. Ct. H.R. 2011) (holding that Poland had failed to comply with its affirmative obligations but stating that "it is not for this Court to indicate the most appropriate means for the State to comply with its positive obligations").

²²⁹ *R.R. v. Poland* ¶ 199.

articulated by Professor Copelon and the reproductive justice movement.²³⁰ However, courts have recognized that even absent affirmative government obligations, there are constitutional limitations to the government's discretion to determine what it will or will not fund. This approach was adopted by the state abortion funding cases in rejecting *Harris's* holding that a discriminatory funding scheme cannot impose an unconstitutional obstacle.²³¹ Instead, the state cases held that government funding programs cannot impose conditions that discriminatorily burden the exercise of a fundamental right or make invidious distinctions between classes of citizens.²³²

While the state decisions continued to reject an affirmative obligation to ensure that women are able to access abortion services,²³³ they held that when the government enacts a policy or program conferring benefits it must allocate them in a neutral

²³⁰ See *supra* Part I.

²³¹ *Women of the State of Minn. by Doe v. Gomez*, 542 N.W.2d 17, 29–30 (Minn. 1995) (“[T]o the extent that *McRae* stands for the proposition that a legislative funding ban on abortion does not infringe on a woman’s right to abortion, we depart from *McRae*.”); *Doe v. Maher*, 515 A.2d 134, 156 (Conn. Sup. Ct. 1986) (“[E]xcepting from the medicaid program of one single medical procedure which is absolutely necessary to preserve the health of the woman . . . constitutes an infringement of the right of privacy . . . under [the Connecticut constitution]”).

²³² *Moe v. Sec’y of Admin. & Fin.*, 417 N.E.2d 387, 401 (Mass. 1981) (“While the State retains wide latitude to decide the manner in which it will allocate benefits, it may not use criteria which discriminatorily burden the exercise of a fundamental right.”); *State, Dep’t. of Health & Soc. Servs. v. Planned Parenthood of Alaska, Inc.*, 28 P.3d 904, 910 (Alaska 2001) (stating that while the state “may legitimately attempt to limit its expenditures . . . a State may not accomplish such a purpose by invidious distinctions between classes of its citizens”).

²³³ The state decisions uniformly emphasized their rejection of an affirmative government obligation to ensure that women can access abortion or other health care services. *Comm. To Defend Reprod. Rights v. Myers*, 625 P.2d 779, 780 (Cal. 1981) (“[T]he state has no constitutional obligation to provide medical care to the poor.”); *Gomez*, 542 N.W.2d at 28 (noting that plaintiffs arguments relied on the fact that differential treatment interfered with women’s decision-making process rather than a state obligation to fund the exercise of every constitutional right); *Women’s Health Ctr. of W. Va., Inc. v. Panepinto*, 446 S.E.2d 658, 666 (W. Va. 1993) (stating that Appellees’ assertion that “the state is not obligated to pay for the exercise of constitutional rights” was true); *Right to Choose v. Byrne*, 450 A.2d 925, 935 n.5 (N.J. 1982) (“[T]he right of the individual is freedom from undue government interference, not an assurance of government funding.”); *Simat Corp. v. Ariz. Health Care Cost Containment Sys.*, 56 P.3d 28, 31–32 (Ariz. 2002) (“[W]e do *not* hold that Arizona’s right of privacy entitles citizens to subsidized abortions.”); *Alaska Dep’t of Health*, 28 P.3d at 906 (stating that the issue is “not whether the state is generally obligated to subsidize the exercise of constitutional rights for those who cannot otherwise afford to do so”); *Planned Parenthood Ass’n, Inc. v. Dep’t. of Human Res. of State of Or.*, 663 P.2d 1247, 1255 (Or. App. 1983).

way.²³⁴

Thus, although the state does not have an obligation to fund health care or a woman's decision to exercise her right to have an abortion, once the government takes on the obligation to fund health care for the poor, it must not do so in a way that coerces women's procreative and reproductive health choices.²³⁵ The state decisions held that the adoption of a discriminatory funding scheme implicated fundamental rights, triggering heightened scrutiny under a privacy and due process analysis²³⁶ or an equal protection analysis.²³⁷ The Massachusetts Supreme Court wrote:

As an initial matter, the Legislature need not subsidize any of the costs associated with child bearing, or with health care generally. However, once it chooses to enter the constitutionally protected area of choice, it must do so with genuine indifference. It may not weigh the options open to the pregnant woman by its allocation of public funds; in this area, government is not free to "achieve with carrots what [it] is forbidden to achieve with sticks."²³⁸

The Alaska Supreme Court similarly emphasized that "the underly-

²³⁴ See, e.g., *Myers*, 625 P.2d at 781 (contrasting the *McRae* Court's holding that the federal Constitution does not require justification for discriminatory treatment as long as the program "placed no new obstacles in the path of the woman seeking to exercise her constitutional right" with the California line of cases holding that discrimination in government benefits requires strict scrutiny whether or not a new obstacle is imposed); *Panepinto*, 446 S.E.2d at 666 (holding that the common benefit clause of the state constitution imposes a neutrality requirement when the state provides a vehicle for the exercise of a constitutional right).

²³⁵ *Gomez*, 542 N.W.2d at 27 (noting that the right to privacy includes the right to control one's own body and the right to procreation without state interference); *Maher*, 515 A.2d at 152 ("[E]ven though the poverty of the plaintiff women was not the state's making and there may have been no constitutional obligation to pay for the medical treatment for the poor, once the state has chosen to do so it must preserve neutrality.").

²³⁶ *Maher*, 515 A.2d at 156-57 (applying strict scrutiny); *Gomez*, 542 N.W.2d at 31 (applying strict scrutiny); *Moe*, 417 N.E.2d at 404 (applying a balancing test).

²³⁷ Although each of the courts found that heightened scrutiny was required given the nature of the right at issue, consistent with their state equal protection jurisprudence, they applied slightly different tests. See, e.g., *Simat Corp.*, 56 P.3d at 32 (applying strict scrutiny analysis because of the fundamental right in question); *Byrne*, 450 A.2d at 934 (applying a balancing test); *Alaska Dep't of Health*, 28 P.3d at 909 (holding that Alaska's sliding scale review requires strict scrutiny when the exercise of a constitutional right is involved); *Maher*, 515 A.2d at 159 (ruling that because of the fundamental right at issue the state "must establish both a compelling state interest [. . .] and that no less restrictive alternative is available"); *Dep't of Human Res. of State of Or.*, 663 P.2d at 1247 (applying a test balancing the "detriment to affected members of the class [. . .] against the state's ostensible justification for the disparate treatment").

²³⁸ *Moe*, 417 N.E.2d at 402 (quoting LAWRENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW 933 n.77 (1978)); *Panepinto*, 446 S.E.2d at 666; *Maher*, 515 A.2d at 153; *Simat Corp.*, 56 P.3d at 36.

ing logic” of all the state cases is that “when state government seeks to act for the common benefit, protection, and security of the people in providing medical care for the poor, it has an obligation to do so in a neutral manner so as not to infringe upon the constitutional rights of our citizens.”²³⁹

The neutrality principle espoused in these decisions looks at the overall impact of the funding scheme rather than focusing on the decision not to fund. The Minnesota Supreme Court wrote that the right to privacy protects a “woman’s decision to abort” and that “any legislation infringing on the decision-making process . . . violates this fundamental right.”²⁴⁰ The cases reject *Harris’s* arbitrary distinction between coercive government acts that burden the exercise of a right and coercive allocation of benefits to fund government preferences where women do not have the means to fund another choice.²⁴¹ Justice Brennan expressed this view in his dissent in *Harris*:

The fundamental flaw in the Court’s due process analysis . . . is its failure to acknowledge that the discriminatory distribution of benefits of governmental largesse can discourage the exercise of fundamental liberties just as effectively as can an outright denial of those rights through criminal and regulatory sanctions.²⁴²

Applying the neutrality principle articulated by the state cases and the dissent in the *Harris* decision, current law allowing the federal and state governments to use Medicaid benefits to coerce women’s reproductive health and procreative decisions would be impermissible.

C. *Freedom from Government Prohibitions on Private Health Insurance: Chaoulli v. Quebec*

As discussed above, current U.S. abortion funding restrictions would violate affirmative government obligations to ensure that wo-

²³⁹ *Alaska Dep’t of Health*, 28 P.3d at 908 (quoting *Panepinto*, 446 S.E.2d at 667); see also *Myers*, 625 P.2d at 781; *Gomez*, 542 N.W.2d at 28; *Byrne*, 450 A.2d at 937; N.M. Right to Choose/NARAL v. Johnson, 975 P.2d 841, 856 (N.M. 1998); *Simat Corp.*, 56 P.3d at 36 (noting a consistency in cases “in the view that funding bans that discriminate against abortions medically necessary only to preserve the health of indigent women were unsustainable once the state had undertaken to provide medically necessary care”).

²⁴⁰ *Gomez*, 542 N.W.2d at 31.

²⁴¹ *Alaska Dep’t of Health*, 28 P.3d at 909 (“Judicial scrutiny of state action is equally strict where the government by selectively denying a benefit to those who exercise a constitutional right, effectively deters the exercise of that right.”).

²⁴² *Harris v. McRae*, 448 U.S. 297, 333–34 (1980) (Brennan, J., dissenting), cited by *Gomez*, 542 N.W.2d at 24, 29.

men have meaningful access to abortion under developing international standards articulated by international bodies and the high courts in Colombia and Nepal. Even absent the recognition of affirmative government obligations, the funding restrictions violate a constitutional standard that requires government neutrality as held by the U.S. state court decisions. The new state legislation banning private insurance for abortion arguably poses even greater constitutional problems by creating a government obstacle to individuals' ability to access private health care.

In 2005, the Supreme Court of Canada found that a prohibition on private health insurance violated the right to life, personal security, inviolability, and freedom under section 1 of the Quebec Charter of Human Rights and Freedoms. *Chaoulli v. Quebec* involved a challenge to a Quebec statute that prohibited the purchase of private health insurance for services covered by the public health care system.²⁴³ The legislation was adopted to preserve the integrity of the public health care system²⁴⁴ and did not reflect any policy against the provision of a specific type of service. Notably, Quebec only prohibited the purchase of private health care insurance.²⁴⁵ Individuals in need of health services could still purchase the services directly without insurance coverage.²⁴⁶ They could also access health services through the public health system, but would be subject to lengthy waits.

A majority of four justices found that the law violated the Quebec Charter's analogue to Section 7 of the Canadian Charter of Rights and Freedoms, which provides for the right to "life, liberty and security of the person." Three of the justices also found that the provision violated Section 7²⁴⁷ of the Canadian Charter based on the denial of "the right to access alternative health care"²⁴⁸ and

²⁴³ *Chaoulli v. Quebec (Attorney General)*, [2005] S.C.C. 35 (Can.). For further discussion of *Chaoulli*, see Soohoo & Goldberg, *supra* note 36, at 1058–59; Hill, *supra* note 103, at 527.

²⁴⁴ *Chaoulli*, 1 S.C.C. at 45.

²⁴⁵ *Id.* at 66–67.

²⁴⁶ *Id.*

²⁴⁷ Canadian courts generally interpret Section 7 to impose negative obligations rather than positive duties to provide health care. Mel Cousins, *Health Care and Human Rights After Auton and Chaoulli*, 54 MCGILL L.J. 717, 737 (2009) ("[T]he courts have, to date, taken a limited view of *Chaoulli* and have not been prepared to adopt the somewhat expansive approach of that judgment so as to impose positive duties on the state in the area of health care under section 7 of the *Charter*."); Joanna N. Erdman, *In the Back Alleys of Health Care: Abortion, Equality, and Community in Canada*, 56 EMORY L.J. 1093, 1110 (2007).

²⁴⁸ *Chaoulli*, 1 S.C.C. at 84 (McLachlin, C.J., and Major & Bastarache, J.J., concurring).

the “loss of control by an individual over [his or] her own health.”²⁴⁹

The concurring opinion found that the ban limited “access to private health services by removing the ability to contract for private health care insurance.”²⁵⁰ Although private services were available, the justices found that as a practical matter most individuals rely upon health insurance to cover health expenses and that as a result of the ban only the very rich would have access to private health care and that most Quebecers would be subject to lengthy delays resulting in adverse physical and psychological consequences.²⁵¹ The majority opinion similarly found that the ability to obtain private health care without insurance was “almost illusory” because “[t]he prohibition on private insurance creates an obstacle that is practically insurmountable for people with average incomes.”²⁵²

Applying the Canadian concept that the right to personal inviolability and security prohibits government restrictions that undermine individuals’ ability to access health care, current state law bans on private insurance that prevent women from accessing abortion care by prohibiting health insurance coverage would be impermissible. Although the Supreme Court has not held that the right to privacy encompasses the right to be free from government obstacles in accessing health care,²⁵³ some state courts have adopted a view similar to the Canadian Supreme Court that the right to privacy and personal security may include the right to preserve and protect one’s health.²⁵⁴

Although the approaches adopted by the high courts in other countries and the state courts that have struck down Medicaid funding restrictions diverge from current Supreme Court jurispru-

²⁴⁹ *Id.* at 85.

²⁵⁰ *Id.* at 66–67.

²⁵¹ *Id.* at 66–68.

²⁵² *Id.* at 45.

²⁵³ *But see* Hill, *supra* note 103, at 531–37 (arguing that the “right to make medical treatment decisions without government interference—run[s] through a long line of Supreme Court and lower court cases.” Although the “negative constitutional right to health” is not explicitly referred to as the basis for a Supreme Court holding “it is a strain that intersects and overlaps with other rights in a wide range of substantive due process cases.”). *Id.* at 531.

²⁵⁴ *Doe v. Maher*, 515 A.2d 134, 151 (Conn. Sup. Ct. 1986); *Right to Choose v. Byrne*, 450 A.2d 925, 934 (N.J. 1982) (citing *Tomlinson v. Armour & Co.*, 70 A. 314 (N.J. 1908), for the proposition that, “[a]mong the most [important] of personal rights, without which a man could not live in a state of society, is the right of personal security, including ‘the preservation of a man’s health from such practices as may prejudice or annoy it’”).

dence, they provide a possible road-map for future arguments to change and advance the law at the state or federal level. They also provide a normative framework for a more robust concept of reproductive rights that can be used in legislative and political advocacy and grassroots organizing and mobilization. The concept of a government obligation to ensure that women can access their rights can be used to encourage public dialogue around the questions asked by the Supreme Court of Nepal: are services affordable and accessible and if not, what should the government be doing to make them so? This dialogue would support efforts to beat back existing abortion funding restrictions, but would also support the creation of government programs to address other structural barriers that prevent women from accessing reproductive health services. At a more modest level, the concept of government neutrality could support efforts to prohibit discriminatory health care coverage in both public health care and the private insurance market.²⁵⁵

CONCLUSION

The Supreme Court's abortion funding cases allowed the federal government to use Medicaid funding to create, as a practical matter, a different set of rights for the rich and the poor. Ironically, rather than expanding insurance coverage for medically necessary abortions, health care reform is likely to result in the largest expansion of the Hyde restrictions since the amendment went into effect in 1977. These restrictions will not only affect low income women who receive health care coverage from the federal government, but will also be extended to women who buy their own health insurance through the new insurance exchanges and on the private market.

In the 1980s, the reproductive rights movement failed to sufficiently mobilize in response to the abortion funding cases. The failure to challenge the Supreme Court's conception of reproductive choice as a negative right or its assertion that Congress had the

²⁵⁵ Laura Bassett, *Reproductive Parity Act: Washington Considers Groundbreaking Abortion Rights Law*, HUFFINGTON POST POLITICS (Jan. 13, 2012, 5:02 PM) available at http://www.huffingtonpost.com/2012/01/13/washington-abortion-reproductive-parity-act_n_1205415.html. An example of legislation inspired by the neutrality principle is the Reproductive Parity Act, introduced in Washington State in 2012. *Id.* Although it failed to pass, the Act would have required that every insurance policy that covered maternity care also cover abortion. *Id.* Sponsors described the bill as an attempt to ensure that the implementation of the ACA does not undermine women's abortion coverage. *Id.*

discretion to manipulate Medicaid health benefits to coerce poor women's reproductive health decision-making and procreative autonomy paved the way for increased abortion restrictions in the 1990s and the current legislative attempts to impose abortion insurance restrictions on all women.

Because current state laws banning private insurance coverage for abortion services do not constitute "public funding restrictions" allowed under *Harris v. McRae*, courts may hold that they are unconstitutional under the improper purpose prong of the undue burden standard. However, prohibiting private insurance bans is only a step toward "winning back what we have lost." The Supreme Court's abortion funding cases opened the door to the use of government programs to coerce women's reproductive health and procreative decision-making based on the formalistic distinction that government funding allocations do not create new obstacles for poor women who seek an abortion. *Casey* went further, holding that states can impose an obstacle as long as it does not have the purpose or effect of creating a substantial obstacle. These standards have resulted in a steady stream of legislation and restrictions designed to whittle away women's access to abortion services, to create a right under the law that is not accessible in fact.

Although the neutrality standard adopted by the state courts that struck down Medicaid funding restrictions would be a step in the right direction, a woman's right to reproductive autonomy cannot be truly protected absent legal and political recognition that the government has an affirmative obligation to ensure her rights. This standard would require that the government adopt programs to support a woman's right to have an abortion and prohibit policies designed to coerce her decisions or to thwart her ability to exercise her rights.