

THE SEEDS OF EARLY CHILDHOOD

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The image of newborn babies wrapped in identical blankets, lying side by side in hospital bassinets, one indistinguishable from the next, is both familiar and pervasive. It's a sweet image that suggests the commonality of the life cycle. The irresistible inference is that those babies—all babies—leave life's starting line together. Each is safe, clean, nurtured, and swaddled, under the watchful eye of a mother, perhaps a father, and an array of medical providers. But the reality is quite different. And while focusing on early childhood—those crucial years from zero to five—is necessary and long overdue, we need to train our lens to earlier points in time as well in order to understand the inequality, racism, and poverty that cements different life trajectories for children before they even start kindergarten. Even the hospital nursery is not a level playing field.¹

Pre-birth inequalities are not natural or inevitable. Rather, we create and cement policy choices that reduce access to adult healthcare, restrict accessible contraception, impede access to abortion, and deny prenatal care.² Together, these choices mean that, in the United States, we maintain very high rates of unwanted pregnancy and increasingly high rates of maternal mortality and morbidity, burdens that fall disproportionately on women of color and women of lower socioeconomic status.³ Equality demands that we address these disproportionate burdens.

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1. This essay builds on some ideas first explored in online commentary. See Joanna L. Grossman, *What Women Are Not Getting for Valentine's Day This Year: Access to Reproductive Health Care Under the Trump Administration*, JUSTIA'S VERDICT (Feb. 14, 2017), <https://verdict.justia.com/2017/02/14/women-not-getting-valentines-day-year> [https://perma.cc/U5WT-54J2]; Joanna L. Grossman, *Sex, Lies, and Trump's Rollback of the Contraceptive Mandate*, JUSTIA'S VERDICT (Oct. 10, 2017), <https://verdict.justia.com/2017/10/10/sex-lies-trumps-rollback-contraceptive-mandate> [https://perma.cc/4ELL-YQ5N]; Joanna L. Grossman, "Deadly Deliveries": USA Today Report Sheds Disturbing Light on Shocking Rates of Maternal Mortality in the United States, JUSTIA'S VERDICT (July 31, 2018), <https://verdict.justia.com/2018/07/31/deadly-deliveries-usa-today-report-sheds-disturbing-light-on-shocking-rates-of-maternal-mortality-in-the-united-states> [https://perma.cc/X2E8-JQXQ].

2. See Jessica E. Morse et al., *The Impact of a 72-hour Waiting Period on Women's Access to Abortion Care at a Hospital-Based Clinic in North Carolina*, 79 N.C. MED. J. 205, 205 (2018) ("Twenty-seven states have enacted statutes that require women to wait 24–72 hours after mandated counseling before they can have an abortion.").

3. GUTTMACHER INST., UNINTENDED PREGNANCY IN THE UNITED STATES 1 (2019).

I. CONTRACEPTION, FUNDING, AND THE BATTLE FOR ACCESS

After decades of watching the expansion of access to contraception, we have entered an era of increasing restriction due to ideological battles over reproductive rights and increased power granted to individuals and corporations to interfere with the reproductive healthcare of others ostensibly because of religious beliefs.

The birth control pill was first approved for use in 1960, and the number of women relying on it for contraception greatly increased with the passage in 1970 of Title X, a law that led to the creation of federally supported family planning clinics.⁴ That greatly increased access to contraception for poor women.⁵ The Supreme Court's 1965 decision in *Griswold v. Connecticut*,⁶ in which it ruled unconstitutional a state law criminalizing the sale of contraceptives even to married couples, removed remaining formal obstacles to contraceptive access.⁷ After 1970, the battles over contraception revolved largely around funding and the issue of "contraceptive equity."⁸ One of the flashpoints in this battle has been over coverage by employer-based health insurance plans. It was once relatively uncommon for plans to cover prescription contraceptives (which are used only by women), but that number increased dramatically between 2000 and 2010 due primarily to state mandated-benefit laws that restricted the ability of insurers to sell plans without such coverage.⁹ But even as coverage became widespread, the plans imposed costs through co-payments or deductibles that made contraception unaffordable for many women.¹⁰

After the Affordable Care Act took effect, the Department of Health and Human Services issued regulations that require employer-based health plans to cover prescription contraceptives at no cost to the

4. Public Health Service Act of 1970, Pub. L. No. 91-572, § 6, 84 Stat. 1504, 1506 (1970).

5. *See id.*

6. 381 U.S. 479 (1965).

7. *Id.* at 485. The Court applied the same principle to invalidate a law banning the sale of contraceptives to single people a few years later, bringing to an end an era of restricted access to contraception. *See Eisenstadt v. Baird*, 405 U.S. 438, 453–55 (1972).

8. *See generally* Sarina Schrager et al., *Contraception in Wisconsin: A Review*, 109 WIS. MED. J. 326 (2010) (defining the concept of "contraceptive equality" and explaining its effects on insurance coverage).

9. *See* KAISER FAMILY FOUND., STATE REQUIREMENTS FOR INSURANCE COVERAGE OF CONTRACEPTIVES (2018), <https://www.kff.org/other/state-indicator/state-requirements-for-insurance-coverage-of-contraceptives/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> [https://perma.cc/QR6T-YRG9].

10. *See* GUTTMACHER INST., INSURANCE COVERAGE OF CONTRACEPTIVES (2019), <https://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives> [https://perma.cc/AQ7D-LBSH]; GUTTMACHER INST., CONTRACEPTIVE USE IN THE UNITED STATES (2018), <https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states> [https://perma.cc/4NB6-HQ5U].

patient.¹¹ This 2011 mandate was based on a comprehensive study of health care needs and access in the United States, which was conducted by the non-partisan, congressionally chartered group, the Institute of Medicine (IOM).¹² IOM focused on health outcomes and access, ultimately concluding that contraception is an essential health benefit and that the largest barrier to access is cost.¹³ Based on these findings, the federal agency in charge of implementation put forward Women's Preventive Services Guidelines, which require "coverage without cost sharing" for all FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling.¹⁴ These guidelines reflect the consensus of the medical profession—that women's (good) health depends on access to contraception.¹⁵ The impact of this so-called contraceptive mandate has been enormous. The proportion of women paying for prescription oral contraceptives dropped from twenty percent to less than four percent.¹⁶ In total, more than fifty-five million women can obtain birth control at no cost.¹⁷ The impact of this access is undeniable. There is an obvious and proven connection between greater access to contraception and fewer unintended pregnancies, fewer abortions, and fewer maternal deaths.¹⁸ But the benefits of access are even broader. The ability to control the timing and number of pregnancies is central to a woman's ability to develop her career and obtain economic security.¹⁹

11. 42 U.S.C. § 300gg-13(a)(4) (2012).

12. Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8725, 8726 (Feb. 15, 2012).

13. GUTTMACHER INST., INSTITUTE OF MEDICINE DESIGNATES CONTRACEPTION & RELATED SERVICES AS WOMEN'S PREVENTIVE HEALTH CARE (2011), <https://www.guttmacher.org/article/2011/07/institute-medicine-designates-contraception-and-related-services-womens-preventive> [<https://perma.cc/MVU7-FZQK>].

14. See HEALTH RES. & SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., WOMEN'S PREVENTIVE SERVICES GUIDELINES (2016), <https://www.hrsa.gov/womens-guidelines-2016/index.html> [<https://perma.cc/39DU-ETBS>] (adding to, but also maintaining, the same recommendations made in 2011).

15. See, e.g., John Cleland et al., *Contraception and Health*, 380 LANCET 149, 153 (2012).

16. Haley Stolp & Jared Fox, *Increasing Receipt of Women's Preventive Services*, 24 J. WOMEN'S HEALTH 875, 875 (2015).

17. NAT'L WOMEN'S LAW CTR., THE AFFORDABLE CARE ACT'S BIRTH CONTROL BENEFIT: TOO IMPORTANT TO LOSE I (2017).

18. See, e.g., Frank A. Sonnenberg et al., *Costs and Net Health Effects of Contraceptive Methods*, 69 CONTRACEPTION 447, 456–57 (2004).

19. On the connection between contraceptive access and women's economic empowerment, see, for example, Joanna L. Grossman, *Griswold v. Connecticut: The Start of the Revolution*, JUSTIA'S VERDICT (June 8, 2015), <https://verdict.justia.com/2015/06/08/griswold-v-connecticut-the-start-of-the-revolution> [<https://perma.cc/ZVZ4-6EMZ>].

Abortion, though consistently supported by a majority of Americans, has always nonetheless been controversial.²⁰ Use of birth control, on the other hand, has always been all-but-universally supported, at least until recently.²¹ Federal funding of family planning for poor women was also a consensus position. Before 2010 or so, it was virtually impossible to find people who would say openly that the government should be permitted to block access to birth control or inhibit access. This was not surprising, given the popularity of contraception. Of women who have ever had sex, ninety-nine percent have used contraception other than natural family planning (including ninety-eight percent of Catholic women, despite the Church's official denunciation in response to the development of the birth control pill in 1968).²² Robert Bork, older readers might recall, expressed religious and moral opposition to the Supreme Court's ruling in *Griswold*—and that position sounded the death knell for his confirmation to the Supreme Court in 1987.²³ But such views have re-emerged and found traction with a small but vocal segment of the Republican Party. Religious and moral opposition to contraception is a view now freely expressed, even if not widely popular.²⁴

One successful attack from this perspective has been on the scope of the religious exemption to the contraception mandate. The original regulations mandating contraceptive coverage included a narrow religious exemption.²⁵ But the exemption was in effect expanded by the

20. A recent Gallup poll, which found that sixty-four percent of respondents want the ruling in *Roe v. Wade* to stand, is typical of current polling. Megan Brennan, *Nearly Two-Thirds of Americans Want Roe v. Wade to Stand*, GALLUP (July 12, 2018), <https://news.gallup.com/poll/237071/nearly-two-thirds-americans-roe-wade-stand.aspx> [<https://perma.cc/6Q3S-ZC87>].

21. See Charles F. Westoff et al., *The Structure of Attitudes Toward Abortion*, 47 MILBANK MEMORIAL FUND Q. 11, 26 (1969) (finding, as early as 1965, the overwhelming proportion of women to be in favor of contraception).

22. RACHEL K. JONES & JOERG DREWEKE, GUTTMACHER INST., COUNTERING CONVENTIONAL WISDOM: NEW EVIDENCE ON RELIGION AND CONTRACEPTIVE USE 4 (2011); see also Lisa McClain, *How the Catholic Church Came to Oppose Birth Control*, HUFFINGTON POST (July 16, 2018, 6:03 PM), https://www.huffingtonpost.com/entry/how-the-catholic-church-came-to-oppose-birth-control_us_5b4cd603e4b02538dbcaf463 [<https://perma.cc/H953-6Z34>] (analyzing the ever-changing view of the Catholic church regarding use of contraceptives).

23. See MARK GITENSTEIN, MATTERS OF PRINCIPLE: AN INSIDER'S ACCOUNT OF AMERICA'S REJECTION OF ROBERT BORK'S NOMINATION TO THE SUPREME COURT 211–13 (1992); Robert H. Bork, *Neutral Principles and Some First Amendment Problems*, 47 IND. L.J. 1, 7–12 (1971).

24. See generally Elizabeth W. Patton et al., *How Does Religious Affiliation Affect Women's Attitudes Toward Reproductive Health Policy? Implications for the Affordable Care Act*, 91 CONTRACEPTION 513 (2015) (concluding that, although the majority of religious people support contraception, there exists an identifiable minority that opposes contraceptive measures).

25. U.S. DEP'T OF HEALTH & HUMAN SERVS., FACT SHEET: FINAL RULES ON RELIGIOUS AND MORAL EXEMPTIONS AND ACCOMMODATION FOR COVERAGE OF CERTAIN PREVENTIVE SERVICES UNDER THE AFFORDABLE CARE ACT (2018), <https://www.hhs.gov/about/news/2018/11/07/fact-sheet-final-rules-on-religious-and-moral-exemptions-and-accommodation-for-coverage-of->

Supreme Court's 2014 ruling in *Burwell v. Hobby Lobby Stores, Inc.*,²⁶ in which it held that closely held corporations that are not religious in nature can *have* religious beliefs and, on the basis of those beliefs, demand an exemption.²⁷ Then, after Donald Trump became President, greater incursions on contraceptive access took hold. The Trump administration has engaged in a systematic effort to dismantle the Affordable Care Act entirely, but it has targeted the contraceptive mandate with special force. The administration went far beyond *Hobby Lobby*, rolling back the mandate further to permit any employer to be exempted based on either "sincerely held religious beliefs" or "moral convictions."²⁸ The rollback is premised on a view that is wholly unsupported by science—that contraceptive access promotes risky sexual behavior among teens and adults.²⁹ All evidence is to the contrary, including the results of a program in Colorado that has provided long-acting contraceptives, such as IUDs completely free to teenagers and low-income women.³⁰ The teen birth rate fell forty percent in four years, and the rate of abortion fell at a similar rate.³¹ But rather than implement evidence-based rules and programs, the federal government is following in the footsteps of conservative states that have leaned on ideology rather than science to regulate women's sexual and reproductive health. Texas, by way of example, has doubled down on this approach. Beginning in 2011, Texas has significantly curtailed its family planning funding, which has contributed to a steep rise in its maternal mortality rate, a slower decline in the teen pregnancy rate than in the rest of the country, the highest teen repeat birth rate in the country, and one of the highest rates of sexually transmitted infections for teens.³²

certain-preventive-services-under-affordable-care-act.html [https://perma.cc/T75J-YRTW].

26. 134 S.Ct. 2751 (2014).

27. *Id.* at 2782–83.

28. *See* Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47,792, 47,806 (Oct. 13, 2017); Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47,838, 47,838 (Oct. 13, 2017). On the day these rules were supposed to take effect, a federal district court judge issued a nationwide preliminary injunction preventing enforcement of these exemptions. *Pennsylvania v. Trump*, No. 17-4540 (E.D. Pa. Jan. 14, 2019).

29. *See* Abigail Abrams, *No, Birth Control Doesn't Make You Have Riskier Sex, Researchers Say*, TIME (Oct. 12, 2017), <http://time.com/4975951/donald-trump-birth-control-mandate-sexual-behavior/> [https://perma.cc/N783-JM9G].

30. CO. DEP'T OF PUB. HEALTH & ENV'T, TAKING THE UNINTENDED OUT OF PREGNANCY: COLORADO'S SUCCESS WITH LONG-ACTING REVERSIBLE CONTRACEPTION 41 (2017).

31. *See* Sabrina Tavernise, *Colorado Finds Startling Success in Effort to Curb Teenage Births*, N.Y. TIMES, July 7, 2015, at A1.

32. *See, e.g.*, Kinsey Hasstedt, *The State of Sexual and Reproductive Health and Rights in the State of Texas: A Cautionary Tale*, 17 GUTTMACHER POL'Y REV. 14, 16 (2014); Marissa Evans & Chris Essig, *Dangerous Deliveries: Is Texas Doing Enough to Stop Moms From Dying?*, TEX.

Where a scientist or public health expert would see a cautionary tale, the Trump Administration sees a blueprint. Since taking office in January 2017, President Trump has spearheaded or implemented a dizzying array of rules and orders that adversely affect women's reproductive health care. He has appointed two Supreme Court Justices—Neil Gorsuch and Brett Kavanaugh—both of whom were pre-approved by the Heritage Foundation for their commitments to overturning reproductive rights and both of whom he believes will vote to overturn *Roe v. Wade*.³³ In his very first days in office, Trump reinstated the Mexico City Policy, also known as the Global Gag Rule, which prohibits foreign non-governmental organizations from receiving U.S. aid if they perform abortions, even if funded with non-US money, or provide any information about abortion to patients or clients.³⁴ Although Republican presidents typically reinstate

TRIB. (Jan. 16, 2018), <https://apps.texastribune.org/dangerous-deliveries/> [<https://perma.cc/6AJR-3BFZ>]; see also Jennifer J. Frost et al., *Young Adults' Contraceptive Knowledge, Norms and Attitudes: Associations with Risk of Unintended Pregnancy*, 44 PERSP. SEXUAL & REPROD. HEALTH 107, 114–15 (2012) (discussing the effects of young people's ignorance of contraceptives).

33. 410 U.S. 113 (1973); see Mark Berman, *Trump Promised Judges Who Would Overturn Roe v. Wade*, WASH. POST (Mar. 21, 2017, 10:02 AM), https://www.washingtonpost.com/politics/2017/live-updates/trump-white-house/neil-gorsuch-confirmation-hearings-updates-and-analysis-on-the-supreme-court-nominee/trump-promised-judges-who-would-overturn-roe-v-wade/?utm_term=.7678ae20acfe [<https://perma.cc/58CU-ZTDY>]. Justice Gorsuch wrote a concurring opinion in the lower court opinion in *Hobby Lobby*, in which he argued for a position that would have permitted even greater incursions into the contraceptive mandate than ultimately permitted by the Supreme Court. See *Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114, 1159 (10th Cir. 2013) (Gorsuch, J., concurring). Justice Kavanaugh issued a decision that would have permitted the federal government to obstruct a detained immigrant minor's access to abortion even after a Texas court had granted her permission to proceed. He was reversed by the D.C. Circuit en banc. *Garza v. Hargan*, 874 F.3d 735, 736 (D.C. Cir. 2017) (en banc); see also Dahlia Lithwick & Jed Shugerman, *Kavanaugh Already Has One of the Clearest Records Against Roe of Any Recent Supreme Court Nominee*, SLATE (July 18, 2018, 2:43 PM), <https://slate.com/news-and-politics/2018/07/brett-kavanaugh-has-a-clear-record-against-roe-v-wade.html> [<https://perma.cc/DAB8-D8PE>] (outlining and discussing Justice Kavanaugh's prior decisions in cases that implicated *Roe v. Wade*). In *June Medical Services, L.L.C. v. Gee*, Justice Kavanaugh dissented from an order staying enforcement of a set of abortion restrictions in Louisiana pending review on the merits and, in an unusual move, wrote a dissenting opinion. No. 18A774, 2019 WL 488298, at *1 (Feb. 7, 2019) (Kavanaugh, J., dissenting). Even though the restrictions are virtually identical to those struck down by the Supreme Court in 2016 in *Whole Woman's Health v. Hellerstadt*, 136 S.Ct. 2292 (2016), Justice Kavanaugh would have permitted the restrictions to take effect pending review, despite significant evidence in the record that the restrictions would cause all but one doctor in the State of Louisiana to cease providing abortion care. This action was widely understood as Justice Kavanaugh's declaration of war on abortion rights. See, e.g., Mark Joseph Stern, *Brett Kavanaugh Just Declared War on Roe v. Wade*, SLATE (Feb. 7, 2019, 11:15 PM), <https://slate.com/news-and-politics/2019/02/brett-kavanaugh-june-medical-services-louisiana-john-roberts.html> [<https://perma.cc/S6QA-UJ6Q>].

34. See PRESIDENTIAL MEMORANDUM REGARDING THE MEXICO CITY POLICY (Jan. 23, 2017), <https://www.whitehouse.gov/presidential-actions/presidential-memorandum-regarding-mexico-city-policy/> [<https://perma.cc/Q224-BU9Z>]. On the effect of this policy, and its departure

this rule (and Democratic ones typically withdraw it),³⁵ the wording in this particular order is either carelessly or intentionally broader and increases the scope and impact of the rule to cover ten times as many funding dollars; moreover, it does not exempt organizations working to provide HIV/AIDS relief, which recent Republican presidents have done.³⁶ Because this rule has been withdrawn and reinstated several times, researchers have had the opportunity to study its effects. Research suggests that the gag rule seems to increase rather than reduce the number of abortions because the funding cuts cause family planning clinics to shut down.³⁷ Predictably, the reduction in access to contraception increases the rate of unintended pregnancy—and thus the rate of abortion.³⁸ Trump has taken the additional, unprecedented step of proposing a domestic gag rule that would apply to family planning clinics in the United States as well as abroad.³⁹

The recent shifts in favor of “religious liberty” (or simply conservative ideology) over women’s health are not costless, at least not for many women. As Justice Ginsburg noted in her dissent in *Hobby Lobby*, the direct connection between control over reproduction and women’s ability “to participate equally in the economic and social life of the Nation” is undeniable.⁴⁰ This language came originally from the plurality’s opinion

from past iterations of the same policy, see Joanna L. Grossman, *What Women Are Not Getting For Valentine’s Day This Year: Access to Reproductive Health Care Under the Trump Administration*, JUSTIA’S VERDICT (Feb. 14, 2017), <https://verdict.justia.com/2017/02/14/women-not-getting-valentines-day-year> [<https://perma.cc/HUE3-ZLYY>].

35. See Barbara B. Crane & Jennifer Dusenberry, *Power and Politics in International Funding for Reproductive Health: The US Global Gag Rule*, 12 REPROD. HEALTH MATTERS 128, 129–30 (2004).

36. *E.g.*, Assistance for Voluntary Population Planning, 68 Fed. Reg. 52,323, 52,323 (Sept. 3, 2003).

37. See VANESSA RIOS, INT’L WOMEN’S HEALTH COAL., REALITY CHECK: YEAR ONE OF TRUMP’S GLOBAL GAG RULE 4 (2018).

38. Natalie Rowthorn, *The Costs of Trump’s Global Gag Rule*, AM. PROSPECT (Aug. 8, 2018), <http://prospect.org/article/costs-trump’s-global-gag-rule> [<https://perma.cc/XYE3-N8MD>]; Casey Quackenbush, *The Impact of President Trump’s ‘Global Gag Rule’ on Women’s Health Is Becoming Clear*, TIME (Feb. 2, 2018, 8:14 PM), <http://time.com/5115887/donald-trump-global-gag-rule-women/> [<https://perma.cc/V6AK-8E8F>].

39. Compliance with Statutory Program Integrity Requirements, 83 Fed. Reg. 25,502 (proposed June 1, 2018) (to be codified at 42 C.F.R. pt. 59); Kinsey Hasstedt, *Trump Administration Looks to Impose “Domestic Gag Rule,” Continuing Its Assault on Reproductive Health and Rights*, GUTTMACHER INST. (June 20, 2018), <https://www.guttmacher.org/article/2018/06/trump-administration-looks-impose-domestic-gag-rule-continuing-its-assault> [<https://perma.cc/SQ2G-8S2J>].

40. *Burwell v. Hobby Lobby Stores, Inc.*, 134 S.Ct. 2751, 2787–88 (2014) (Ginsburg, J., dissenting) (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 883, 856 (1992)). On the connection between reproductive rights and women’s economic security, see INST. FOR WOMEN’S POLICY RESEARCH, *THE STATUS OF WOMEN IN THE STATES: 2015* 165–77 (2015).

in *Planned Parenthood v. Casey*,⁴¹ a 1992 ruling in which the Court reformulated but reaffirmed the central holding of *Roe v. Wade*, preserving the essential right of women to terminate a pregnancy before a certain point.⁴²

The economic security of all women is threatened when access to contraception is reduced, but women of low socioeconomic status are disproportionately burdened.⁴³ Currently, low-income women are overrepresented among those who do not wish to become pregnant but are not using contraception.⁴⁴ A report by the Kaiser Family Foundation concluded, for example, that the proposed domestic gag rule would leave many women “with far fewer options to obtain affordable, comprehensive, and high quality family planning care,” at the same time more women are becoming uninsured due to the weakening of coverage under the Affordable Care Act.⁴⁵ Millions of low-income women have relied on public programs and providers for everything from contraception to cancer screenings to STI treatment.⁴⁶ These programs are funded by a combination of sources, including Title X and Medicaid.⁴⁷ Cuts to either or both of those programs will have real and potentially devastating effects on poor women’s access to care.

Federal efforts to curtail funding for family planning are mirrored at the state level, at least in some states. Texas, for example, significantly cut its family planning program in 2011, reducing the total pool of money significantly and restricting participation in the program.⁴⁸ As a result,

41. 505 U.S. 833 (1992).

42. *Id.* at 856 (1992).

43. Research also demonstrates that access to abortion plays an important role in women’s independence and autonomy. *See, e.g.*, Caitlin Knowles Myers, *The Power of Abortion Policy: Reexamining the Effects of Young Women’s Access to Reproductive Control*, 125 J. POL. ECON. 2178, 2222 (2017).

44. KAISER FAMILY FOUNDATION, WOMEN’S SEXUAL AND REPRODUCTIVE HEALTH SERVICES: KEY FINDINGS FROM THE 2017 KAISER WOMEN’S HEALTH SURVEY 13 (2018), <https://www.kff.org/womens-health-policy/issue-brief/womens-sexual-and-reproductive-health-services-key-findings-from-the-2017-kaiser-womens-health-survey/> [https://perma.cc/5GM8-XH8G] (concluding, also, that Trump Administration policies would “disproportionately limit access [to reproductive health care] to low-income and minority women”).

45. LAURIE SOBEL ET AL., KAISER FAMILY FOUNDATION, PROPOSED CHANGES TO TITLE X: IMPLICATIONS FOR WOMEN AND FAMILY PLANNING PROVIDERS 9 (2018), <https://www.kff.org/womens-health-policy/issue-brief/proposed-changes-to-title-x-implications-for-women-and-family-planning-providers/> [https://perma.cc/KHR3-HJ9B].

46. USHA RANJI ET AL., KAISER FAMILY FOUNDATION, FINANCING FAMILY PLANNING SERVICES FOR LOW-INCOME WOMEN: THE ROLE OF PUBLIC PROGRAMS 2 (2017), <https://www.kff.org/womens-health-policy/issue-brief/financing-family-planning-services-for-low-income-women-the-role-of-public-programs/> [https://perma.cc/4YQ9-NKNN].

47. *Id.*

48. Kari White et al., *The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas*, 105 AM. J. PUB. HEALTH 851, 851 (2015).

one-quarter of family planning clinics in the state closed.⁴⁹ Within just a few years, less than half as many women were receiving services from state-funded providers, and many providers reduced the range of services available.⁵⁰ Among the changes implemented in 2011 was a ban on Planned Parenthood affiliates' receiving any state funds.⁵¹ This change "was associated with adverse changes in the provision of contraception," including a reduction in the number of women continuing to use injectable contraceptives and an increase in the number of births covered by Medicaid.⁵² In other words, this study concluded, the ban reduced access to one of the most effective types of contraception and likely increased the number of unplanned births. Another study found that the exclusion of Planned Parenthood caused twenty percent of patients to miss a dose of injectable contraception due to the difficulty of finding a provider, with the burdens falling most heavily on women in rural areas of the state.⁵³ Poor women are the losers in this battle.

II. RESTRICTIONS ON ABORTION

Across the country, taxpayers are paying to defend a seemingly never-ending barrage of new abortion restrictions, passed by conservative legislatures as part of the current anti-abortion strategy. This strategy, which gained momentum in the 1990s, was to impose burdens on abortion providers that would make it difficult, if not impossible, to remain in operation. So-called TRAP laws—targeted regulation of abortion providers—were designed as an end-run to circumvent the protections of *Roe* and *Casey*.⁵⁴ Over one thousand abortion restrictions have been passed by states since *Roe*, one third in just the past seven years.⁵⁵ These laws take a variety of forms, but together they make it more difficult for doctors to provide abortions and more challenging for

49. *Id.*

50. *Id.* at 857.

51. Amanda J. Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 NEW ENG. J. MED. 853, 853 (2016).

52. *Id.*; Molly Redden, *Healthcare Without Planned Parenthood: Wisconsin and Texas Point to Dark Future*, GUARDIAN (Jan. 17, 2017, 6:30 AM), <https://www.theguardian.com/us-news/2017/jan/17/planned-parenthood-congress-wisconsin-texas> [https://perma.cc/9HWU-JUSU].

53. See C. Junda Woo et al., *Women's Experiences After Planned Parenthood's Exclusion From a Family Planning Program in Texas*, 93 CONTRACEPTION 298, 298 (2016).

54. GUTTMACHER INST., TARGETED REGULATION OF ABORTION PROVIDERS (TRAP) LAWS (2018), <https://www.guttmacher.org/evidence-you-can-use/targeted-regulation-abortion-providers-trap-laws> [https://perma.cc/QGR6-LDZL].

55. GUTTMACHER INST., TRENDS IN STATE ABORTION RESTRICTIONS, 2017 (2017), <https://www.guttmacher.org/infographic/2018/trends-state-abortion-restrictions-2017> [https://perma.cc/9SBW-Q5MP].

women to obtain them.⁵⁶ These laws imposed waiting periods, ultrasound requirements, and requirements for clinic architecture—they also banned particular abortions based on timing or method and prohibited coverage of abortion care by private insurance policies.⁵⁷

This anti-abortion strategy was highly successful. Abortion clinics had to close in huge numbers because the restrictions made their operations legally or financially impossible. It left a handful of states with only a single operating clinic.⁵⁸ The Supreme Court drove a nail into this strategy in 2016 when it decided in *Whole Woman's Health v. Hellerstedt*⁵⁹ that two of Texas's TRAP laws were unconstitutional because they imposed too significant a burden on women's access to abortion without any sufficient medical benefits to justify the incursion.⁶⁰ While this decision throws the constitutionality of many other state restrictions into question, it does nothing to bring back the clinics that were forced to close in Texas or elsewhere because of these laws. Indeed, one of the undue burdens identified by the Court was women's impeded access to abortion because so many clinics were forced to close.⁶¹ Moreover, the attacks on abortion access have resulted in reductions in access to other kinds of care, including family planning, prenatal, and primary care.⁶² TRAP laws represent just one type of attack on abortion access, and significant others remain. In fact, abortion restrictions passed recently take more direct aim at *Roe*, banning abortion altogether in some cases or after such an early point in pregnancy that most women wouldn't even know in time to meet the deadline.⁶³ Legislators in some states are queuing up challenges to *Roe* in the hopes that the shift in composition on the Supreme Court might lead to a victory.⁶⁴ It should surprise no one that virtually all barriers to access are disproportionately adverse for

56. GUTTMACHER INST., STATES ENACT RECORD NUMBER OF ABORTION RESTRICTIONS IN 2011 (2012), <https://www.guttmacher.org/article/2012/01/states-enact-record-number-abortion-restrictions-2011> [<https://perma.cc/8GG7-7N67>] (noting that ninety-two different restrictions were passed in just that one year).

57. *Id.*

58. See Catherine Pearson, *The List of States with Only One Abortion Provider Left is Growing*, HUFFINGTON POST (Jan. 27, 2017) https://www.huffingtonpost.com/entry/the-list-of-states-with-only-one-abortion-provider-left-is-growing_us_588a43b7e4b0024605fe772d [<https://perma.cc/NQ2Z-NWMM>].

59. 136 S.Ct. 2292 (2016).

60. *Id.* at 2318.

61. *Id.* at 2317–18.

62. See Rachel Benson Gold & Kinsey Hasstedt, *Lessons from Texas: Widespread Consequences of Assaults on Abortion Access*, 106 AM. J. PUB. HEALTH 970, 970 (2016) (noting reductions in the “accessibility, availability and affordability” of abortion).

63. See, e.g., Julie Bosman & Mitch Smith, *Iowa Passes Abortion Bill With Roe v. Wade in Sights*, N.Y. TIMES, May 3, 2018, at A11.

64. *Id.*

lower-income women.⁶⁵

III. HEALTHY BABIES AND DEAD MOTHERS

Even as maternal mortality rates fall across the globe, they are rising in the United States.⁶⁶ Defined as the death of a woman during childbirth or within one year of giving birth in the absence of another known cause, maternal mortality is measured as a ratio of maternal deaths per 100,000 live births.⁶⁷ The maternal mortality ratio (MMR) allows for comparisons across different populations.⁶⁸ Reducing the MMR has been a goal of governments, NGOs, and other organizations for many decades.⁶⁹ Overall, the MMR has declined significantly since 1990.⁷⁰ The Center for Disease Control (CDC) in the United States started tracking data nationally on maternal death in 1986 in order to compile better data on its causes.⁷¹ Globally, public health advocates have worked hard to reduce the risk of maternal death. Their efforts have been successful, with a forty-four percent reduction in the global rate of maternal death from 1990 to 2015.⁷² Regions with particularly high rates have seen even greater reductions.⁷³ Yet, the rate in the United States has steadily increased over the same period.⁷⁴

The Center for Disease Control using the Pregnancy Mortality Surveillance System, established in 1986, to track maternal death, found an increase from 7.2 maternal deaths per 100,000 live births in 1987 to 18 per 100,000 live births in 2014.⁷⁵ These numbers do not reflect a

65. See Heather D. Boonstra, *Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters*, 19 GUTTMACHER POL. REV. 46, 46 (2016); Christine Dehlendorf & Tracy Weitz, Commentary, *Access to Abortion Services: A Neglected Health Disparity*, 22 J. HEALTH CARE FOR THE POOR AND UNDERSERVED 415, 416 (2011); STANLEY K. HENSHAW ET AL., GUTTMACHER INST., RESTRICTIONS ON MEDICAID FUNDING FOR ABORTIONS: A LITERATURE REVIEW 10 (2009).

66. Allison Schneider, *Maternal Deaths Are Rising in America. Best Mother's Day Gift, Reverse That Trend.*, USA TODAY (May 13, 2018, 9:51 AM), <https://www.usatoday.com/story/opinion/2018/05/10/maternal-deaths-mothers-mortality-column/595818002/> [<https://perma.cc/9E5E-RNPV>].

67. WORLD HEALTH ORG., TRENDS IN MATERNAL MORTALITY 1990 TO 2015: ESTIMATES BY WHO, UNICEF, UNFRA, WORLD BANK GROUP, AND THE UN POPULATION DIVISION 34–36 (2015) [hereinafter TRENDS IN MATERNAL MORTALITY].

68. *Id.* at 1.

69. *Id.*

70. See *id.* at 20.

71. See *Pregnancy Mortality Surveillance System*, CTR. FOR DISEASE CONTROL, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm> [<https://perma.cc/YRG4-CV9P>] [hereinafter *Pregnancy Mortality Surveillance System*].

72. See TRENDS IN MATERNAL MORTALITY, *supra* note 67, at 20.

73. *Id.*

74. *Id.* at 76.

75. See *Pregnancy Mortality Surveillance System*, *supra* note 71.

uniform increase across the nation; some states have vastly higher rates than others.⁷⁶

It's relatively complicated to understand the meaning of these numbers. It is possible that some of the reported increases can be attributed to increased reporting or differences in the way deaths are recorded or reported. But there is plenty of information to suggest that pregnancy and childbirth are simply getting more dangerous in the United States, particularly for more disadvantaged women.⁷⁷ Increasing rates of diabetes and high blood pressure, for example, aggravate pregnancy risk.⁷⁸

A recent study found that among women who give birth each year, 50,000 are severely injured, and 700 die.⁷⁹ These are alarming numbers, which investigative reporters gathered by examining hospital records in three states.⁸⁰ Behind the numbers, the reporters found widespread failures in the medical management of childbirth that permitted preventable deaths to occur.⁸¹ High blood pressure, for example, is a leading cause of maternal mortality, and experts deem sixty percent of such deaths preventable.⁸² Yet, hospitals routinely fail to follow detailed instructions from the American College of Obstetricians and Gynecologists on how and when to treat the condition.⁸³ A similar story could be told about other conditions. A coalition of leading medical societies developed another program, which categorizes risk into "safety bundles," and provides tools and instructions for counteracting each one.⁸⁴ These tools and recommendations are evidence-based and user-friendly and, yet, not always used.

As with virtually every other aspect of sexual and reproductive health, harm is not evenly distributed across the population. Risk for pregnant women is disproportionately high for black women (40 maternal deaths for every 100,000 black women who gave birth, compared with only 12.4

76. *Id.*

77. See e.g., Alison Young, *Deadly Deliveries: How Hospitals Know How to Protect Mothers. They Just Aren't Doing It.*, USA TODAY (July 27, 2018, 4:54 PM), <https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2018/07/26/maternal-mortality-rates-preeclampsia-postpartum-hemorrhage-safety/546889002/> [<https://perma.cc/WU3S-9GKC>].

78. *Id.*

79. *Id.*

80. *Id.*

81. *Id.*

82. BUILDING U.S. CAPACITY TO REVIEW AND PREVENT MATERNAL DEATHS, REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES 6 (2018).

83. *Id.* at 43.

84. See *Alliance for Innovation on Maternal Health Program*, COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE, <https://safehealthcareforeverywoman.org/aim-program/> [<https://perma.cc/AAC7-HVP8>] (last visited Feb. 3, 2019).

white women during the years 2011–2014).⁸⁵ Maternal death is also not distributed evenly across the country, with Louisiana (58.1), Georgia (48.4), and Indiana (43.6) sporting the highest rates.⁸⁶

In several states, commissions to study maternal mortality have been convened. The early results suggest that when lawmakers implement commission recommendations, the rate of maternal death falls because so many deaths are preventable.⁸⁷ California, in this regard, is a good model. It cut the maternal mortality rate in half between 2003 and 2016 by focusing on specific, evidence-based reforms, such as making hemorrhage carts readily available in all hospitals.⁸⁸ Taking a different tack, Alabama reduced its maternal mortality rate by focusing on infant mortality; efforts to expand access to prenatal care indirectly improved maternal health at the same time as infant health.⁸⁹ Texas, meanwhile, has studied the problem extensively, but not instituted the reforms justified by the findings.

While maternal death is a catastrophic moment in reproductive cycle, it is part and parcel of a broken system. The medical profession plays an obvious role in maternal health and well-being, but so do lawmakers. As discussed in this essay, we as a society can choose to do right or do wrong by women and their babies. But we often choose to do wrong due to the confluence of politics, ideology, religion, and money. When lawmakers set policy based on ideology rather than science, mothers and their children suffer. When they are driven to seek short-term cost-savings over long term ones, we see the same effect. These decisions impose burdens on many women, but especially women of color and low-income women.

85. See *Pregnancy Mortality Surveillance System*, *supra* note 71. See also La'tasha D. Mayes, *Black Women Are Dying From a Lack of Access to Reproductive Health Services*, TIME (Jan. 19, 2018), <http://time.com/5109797/black-women-dying-reproductive-health/> [https://perma.cc/7MBT-8GCA]; Nina Martin et al., *Nothing Protects Black Women From Dying in Pregnancy and Childbirth*, PROPUBLICA (Dec. 7, 2017, 8:00 AM), <https://www.propublica.org/article/nothing-protects-black-women-from-dying-in-pregnancy-and-childbirth> [https://perma.cc/WX4B-H4DB].

86. *USA Today Investigation Ranks States with the Highest Maternal Death Rates*, CBS NEWS (July 26, 2018, 1:49 PM), <https://www.cbsnews.com/news/best-and-worst-states-to-give-birth-usa-today-investigation/> [https://perma.cc/9R9S-U9E6].

87. See generally Marian F. MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues*, 128 *OBSTETRICS & GYNECOLOGY* 447, 453 (2016).

88. See Julia Belluz, *California Decided It Was Tired of Women Bleeding to Death in Childbirth*, VOX (Dec. 4, 2017, 11:23 AM), <https://www.vox.com/science-and-health/2017/6/29/15830970/women-health-care-maternal-mortality-rate> [https://perma.cc/E34G-EG9F].

89. See ALABAMA DEP'T OF PUB. HEALTH, *ALABAMA PERINATAL HEALTH ACT ANNUAL PROGRESS REPORT FOR FISCAL YEAR (FY) 2016 PLAN FOR FY 2017*, at 1 (Feb. 2017).

CONCLUSION

Our healthcare system does not dispense care or good outcomes equally. Quite the contrary.⁹⁰ As summarized in a recent brief of the U.S. Department of Health and Human Services, “[m]inority populations, in particular, continue to lag behind whites in a number of areas, including quality of care, access to care, timeliness, and outcomes.”⁹¹ Overall, the Affordable Care Act reduced gaps in healthcare access between rich and poor, white and non-white, and men and women.⁹² Substantial inequalities remain, and attacks on the ACA threaten to return to the previously larger disparities. And these general disparities in access to healthcare are exacerbated by attacks on sexual and reproductive health care. There are racial disparities in every aspect of sexual and reproductive health care.⁹³ Women of color are “less likely to have access to reproductive health care, including medically appropriate contraceptives, annual gynecological exams, and prenatal care.”⁹⁴ Black women have higher rates of unintended pregnancy, particularly for teenagers; these disparities would disappear with the removal of barriers to “cost, access, and knowledge.”⁹⁵ Abstinence-only education, proven not to work yet clung to by many states, disproportionately harms non-white teenagers.⁹⁶

Let’s return to the image of those side-by-side newborn babies in the hospital. Perhaps they look indistinguishable, but the paths that led to that nursery might have been very different—and ensure that the days, weeks, and years after that nursery stay are different as well. That one might have a dead mother is just one of many inequalities that may distinguish one

90. See Samuel L. Dickman et al., *Inequality and the Health-Care System in the USA*, 389 LANCET 1431, 1431 (2017).

91. AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, MINORITY HEALTH: RECENT FINDINGS 1 (Feb. 2013).

92. See, e.g., Adam Gaffney & Danny McCormick, *The Affordable Care Act: Implications for Health-Care Equity*, 389 LANCET 1442, 1442 (2017); CYNTHIA HESS ET AL., THE STATUS OF WOMEN IN THE STATES: 2015, at 215 (2015) (finding that the ACA “has changed the landscape of health care for women, providing more women access to preventive care and other services, yet some women continue to face barriers to obtaining the services they need”).

93. NAT’L ASS’N SOCIAL WORKERS, HEALTH DISPARITIES PRACTICE UPDATE: REPRODUCTIVE HEALTH DISPARITIES FOR WOMEN OF COLOR 1 (2004).

94. See *id.*; CENTER FOR REPRODUCTIVE RIGHTS, REPRODUCTIVE INJUSTICE: RACIAL AND GENDER DISCRIMINATION IN U.S. HEALTH CARE 6 (2014).

95. Melody Goodman et al., *Reducing Health Disparities by Removing Cost, Access, and Knowledge Barriers*, 216 AM. J. OBSTETRICS & GYNECOLOGY 382.e1, 382.e1 (2017).

96. See Risha K. Foulkes, *Abstinence-Only Education and Minority Teenagers: The Importance of Race in a Question of Constitutionality*, 10 BERKELEY J. AFRICAN-AMERICAN L. & POL’Y 3, 51 (2008); Sarah Smith Kuehnle, Note, *Abstinence-Only Education Fails African American Youth*, 86 WASH. U. L. REV. 1241, 1271 (2009); Kathrin F. Stanger-Hall & David W. Hall, *Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the U.S.*, 6 PLOS ONE 1, 10 (2011).

baby from the next. A system that delivered the level playing field represented by those identical blankets would do many things differently. It would prioritize comprehensive sex education to facilitate informed behavior and decision-making. It would expand rather than constrict access to contraception. It would make abortion accessible. It would improve access to prenatal and post-partum care, as well as infant care. It would also expand access to sexual and reproductive health care throughout the reproductive life cycle. The federal and state governments should work toward these goals because they will improve the lives of mothers and their children—and give children a more equal start.