Expanding Reproductive Rights to Indigent Noncitizens:  
A Prioritarian Goal of Reproductive Justice

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Abstract

The terrain of reproductive policy in the U.S. must be reformed with the goal of concentrating on the reproductive rights of noncitizens. Given the long history of failing to address the reproductive interests of the least advantaged members of society, this article identifies the creation of the constitutional rights to contraception and abortion as on-demand, pay-to-play rights through Supreme Court jurisprudence and legislatively through the Hyde Amendment as obstacles to reproductive access. Namely, these forces disadvantage indigent pregnant women, their families, and their future children, a disadvantage most palpably felt by noncitizens. The failure to tend to the reproductive interests of the least advantaged members of society thus has reverberating consequences, further entrenching social inequalities for future generations. The primary protections available to pregnant, indigent noncitizens are the limited, emergency-related protections of the EMTALA, which will be explored as the manner in which noncitizens can exercise reproductive rights by unpacking judicial, administrative, and professional interpretations of that law. While that statute, DACA, and other measures are steps in the right direction, this article concludes that reproductive policy still must be significantly reformed to offer more expansive care to this group.

Keywords: History of Reproductive Rights, Abortion, Contraception, Non-Citizens, DACA, EMTALA

I. Introduction

With the Deferred Action for Childhood Arrivals (DACA) program at the forefront of current politics, focus remains on the binary choice of whether or not to grant the most fundamental of rights: citizenship. Exceptions do exist to the general presumption that only citizens have rights, such as the right of noncitizens to file suit in federal courts under the Alien Tort Claims Act, or the procedural protections they are guaranteed through the criminal

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process. This article traces a particular thread through the exceptions granted for noncitizens and “qualified” noncitizens like asylees, refugees, and lawful permanent residents in terms of their legal rights regarding reproductive choice. In doing so, it thus unpacks a novel jurisprudence on this contentious topic and fills a gap in the literature related to noncitizen rights—indeed, most sources approaching the topic of noncitizen rights focus simply on establishing that they have them. The rare sources that do focus on the specific character of noncitizen rights invariably focus on bare procedural rights, or rights to asylum or to escape a humanitarian crisis.¹

Consider, in contrast, the plight of a pregnant woman in labor without any immigration documentation or insurance. It is likely that she has not had the opportunity to speak with a genetic counselor before conception, unlikely that she will undergo a quad screen during her pregnancy, and perhaps even unlikely that she will benefit from having the results returned to her from the robust newborn screening programs operating in all fifty states. Unless she can find a nearby safety net clinic or substantial-share hospital for her delivery that is funded to treat the indigent and uninsured, her primary protection at the federal level comes by way of the Emergency Medical Treatment and Active Labor Act (EMTALA), which assures that a hospital receiving federal funds cannot “dump” her if she is in labor and delivery is imminent.² They can transfer her if it does not pose an undue risk to the woman and fetus; otherwise they must perform the delivery but very little beyond that, so long as she has stabilized. At the state level, less than half of states explicitly permit Medicaid funds, via emergency medical aid, to be allocated to prenatal care (such as reproductive technologies) for undocumented individuals.

By unpacking the concept of noncitizen reproductive rights, this article aims to begin a new conversation, one which considers whether reproductive rights should be included in the list of basic, fundamental rights accorded even to those without citizenship. Part I sketches some historical contours that help to contextualize the rights of non-citizens within the regime of reproductive rights that developed in United States from the nineteenth into the early twentieth century. Part II continues that history into the latter half of the twentieth century, concentrating on the significance of the Supreme Court’s language that carved out

¹ See sources infra note 54.

² 42 U.S.C. § 1395dd; 42 C.F.R. § 489.24(b)(1) (defining “labor” under EMTALA as “childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta”); see also infra Section III.
contraception and abortion as “fundamental” rights, fundamental because of their centrality to personal dignity and individual autonomy. Part III describes how this jurisprudence of reproductive policy has created and sustained a “pay-to-play,” “on-demand” approach to reproductive rights: they are available to those who can afford them, they can be accessed for any reason, and in many ways they are only available to citizens. Part IV both suggests how the past half century of reproductive rights could have unfolded by prioritizing the needs of the least advantaged, and how policy in the present can retrain its sights on that goal.

This article thus illustrates the need for reform in this inadequate terrain, for how we attend to the reproductive interests of the least well-off members of society reflects, shapes, and constitutes the type of community we will become in the future. That is, promoting indigent noncitizen access to reproductive tools—from prenatal vitamins to contraception, genetic screening and counseling, prenatal care, and potentially even abortion—is not just imperative because reproductive rights are defined to be fundamental and central to the personal dignity of those living in the present, but also because of the palpable effect this could have on the lives of future citizens they create.3  

I. Race and Class in Reproductive Regulation of the Nineteenth and Early Twentieth Century

Reproductive bodies have long been subject to what Michel Foucault describes as “biopolitical” power,4 through the ways in which authorities and institutions work to shape the conditions of health, life, reproduction, and death in the population. One of the clearest stories of this biopolitical power over reproductive bodies in the United States pivots around the waxing and waning of access to contraception and abortion. The story begins in a deregulated landscape of reproductive policy that had generally lasted from colonial times until the mid-nineteenth century, but one that had grown highly regulated by the dawn of the twentieth century.

3 See sources infra Section IV (suggesting undocumented individuals in studied areas were less likely to access prenatal care, and may be at a greater risk for labor complications, fetal distress, and specific adverse neonatal outcomes like neural defects).

At the turn of the nineteenth century, there were no laws governing the provision of contraceptives, abortifacients, and abortion services. Still, this is not to say that reproductive choice at this time was unregulated. To the contrary, forces such as social mores, stigma from family, friends, and community, and cultural expectations all worked to shape, constrain, and form the boundaries of individual reproductive freedom. Many writing in the “reform physiology” movement of the early and mid-nineteenth century, like Robert Dale Owen and Charles Knowlton, were early movers in jostling moral opposition to sexual practices like *coitus interruptus* and douching that could be used for family planning purposes.5 Other reform physiologists, like the nutritionist Sylvester Graham, worked in the opposite direction in arguing masturbation, for example, was a moral and physiological plague that was the cause of much ill health across the country.6

However, these cultural and moral oppositions to family planning eventually diffused. By midcentury, the era of “Restellism” had become apparent, a period characterized by a *laissez-faire* terrain of reproductive policy with virtually no regulations over abortionists, and with numerous purveyors of patent medicines advertising the latest contraceptive devices and abortifacient drugs, advertising facilitated by the growth of urban centers, as well as new railroads, mail services, and other methods of reaching those in the hinterlands and frontiers. On the front end, this era of Restellism was made possible by the growing acceptance of practices like masturbation, douching, and the rhythm method, without a regulatory infrastructure in place. It thus “began” in the early-to-mid nineteenth century with the swell in tracts, treatises, and advertisements encouraging people to take more control over family, as well as major abortion syndicates like that of Madame Restelle (Ann Trow). On the back end, the period of Restellism was bounded by the legal response to this sexual liberalization—namely, the efforts in the latter-nineteenth century of the American Medical Association (AMA), Anthony Comstock, and others to proscribe the use of contraceptives and abortion.

As a result of their efforts, from the mid-nineteenth into the twentieth century, this terrain of reproductive policy went from a state of deregulation to a highly regulated one at the federal level and in state laws across the country. Distribution and commerce

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6 Sylvester Graham, *Discourses on a Sober and Temperate Life* (1833).
of contraceptives came to fall within the ambit of Comstock laws, which banned such materials as obscene. Further, physicians and state medical societies engaged in a lobbying campaign that led to abortion being criminalized across the country by the end of the nineteenth century. Historians and sociologists have described this anti-abortion effort by physicians in the AMA, most notably Horatio Storer, as one fueled by the professional motives of “regular” physicians to exclude practitioners of alternative forms of medicine and healing like hydropathy and botanism. In other words, beyond being a site for contesting religious and sexual morality, abortion also revealed itself to be a market issue of economic competitiveness for medical practitioners. The AMA would maintain that abortion was contrary to the Hippocratic Oath, and was therefore inappropriate for doctors within its ranks. Consequently, anti-abortion statutes could serve as vehicles for attempting to force out of the market those midwives and practitioners of alternative forms of medicine willing to accept the lucrative fees offered for abortions after the era of Restellism was eclipsed by Comstock laws and the AMA’s anti-abortion statutes.7

Two features of reproductive policy that would last from the late 1800s into the 1960s are important to stress in setting the stage for introducing the topic of noncitizen reproductive rights in the U.S. First, some historians and sociologists suggest exceptions carved out for the life interests of the mother in most anti-abortion statutes, as well as a general reluctance to prosecute abortionists, meant that regular physicians had considerable discretion in construing a pregnant woman’s “life” interests broadly, not just performing abortions when continued pregnancy or obstructed labor threatened to kill the woman, but also when having a subsequent child would alter the future trajectory of her life in a way she did not want.8 Indeed, though abortion surveillance data is limited for the first half of the twentieth century, one prevalent interpretation of the available data is that the abortion rate in the early twentieth century was comparably similar to abortion rates after Roe v. Wade.9 In other words, this discretion that physicians worked into anti-abortion statutes would suggest that elective abortions remained available to many of the white, middle- and upper-class clientele

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8 Mohr supra note 7 at 238–41; Luker supra note 7 at 34.

9 Luker supra note 7 at 45–54.
who could afford the services of regular physicians—doctors whose academic training and scientific practice of medicine slowly began to distinguish itself from alternative forms of medicine after numerous developments in scientific medicine in the late 1800s and early 1900s. Thus, inasmuch as regular physicians came to offer safer abortions, sterilization, and childbirth procedures, these options were only available to the particular demographic that used the services of such physicians.

Second, the intersection of Gilded Age and Progressive era immigration patterns with reproductive policy would continue to prioritize native-born, middle and upper-class reproductive interests. During the decades of the late-nineteenth century when the U.S. experienced rapid industrial and urban growth, increasing average wages, and railroad construction, prospecting, and other possibilities for wealth to be made on its frontiers, significant waves of immigrants would arrive seeking new opportunities. Anti-immigration and xenophobic sentiments during this time would clearly make themselves known in immigration quotas and bans like the Chinese Exclusion Act. Further, the undeniable decrease in the fertility rate of American women due to family planning practices led figures like Theodore Roosevelt to express the worry of “race suicide.” This nativist lament, echoed by numerous others, often stemmed from a perception that incoming surges of Catholic immigrants in particular were arriving, having numerous children, and refusing to use contraception and abortion because these tools were contrary to their religious morality. As a result, natives who used reproductive tools to control their family size were accused of failing to keep up their ranks by not having enough children, and leaving it for immigrants to “possess New England,” as one treatise writer would opine in 1891.

Indeed, from 1800 to 1900, the fertility rate of the average native-born American woman had fallen from seven to three children; among other reasons, this profound shift could be attributable to a mixture of changing social mores and sexual practices, better scientific and general understanding of fertility, and increasing use of contraceptives, abortifacients, and

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10 But see Yick Wo v. Hopkins, 118 U.S. 356 (1886) (finding a San Francisco ordinance regulating laundry facilities in wooden buildings, which were run in the city overwhelmingly by Chinese people, to be race-neutral on its face but nevertheless to be a violation of equal protection).


abortion services over the nineteenth century.\textsuperscript{13} The AMA did threaten expulsion from its ranks for those physicians found to have contravened anti-abortion statutes and performed an abortion, but the earliest broad surveys capturing a picture of the country’s sexual behavior in the early twentieth century—the Kinsey Reports—suggest abortion was not an uncommon practice. Of the 6,000 women surveyed in these studies in the 1940s and 1950s, between a fifth and a quarter of married women reported aborting a pregnancy, with almost 90\% of extramarital pregnancies also ending in abortion.\textsuperscript{14}

Therefore, on the one hand, a native, white, middle and upper-class demographic would have initially had better access to safer abortion services and sterilization procedures, better access than most minorities within the country and immigrants arriving from elsewhere. These facets of reproductive policy took more concrete shape in the early twentieth century in the context of the eugenics movement. Indeed, America’s eugenics movement was the overwhelming manifestation of reproductive policy in the first half of the twentieth century, and it continued to use reproductive tools to promote ideals of race and class that deepened the xenophobic sentiments of the Gilded Age and Progressive Era. While the rediscovery of Mendelian inheritance at the turn of the century would soon lead to rapid advances in understanding the etiology and nature of numerous genetic diseases, eugenicists and hereditarians like Charles Davenport would be quick to sweep a range of societal ills under the aegis of heredity. Indeed, many within the scientific, medical, and legal communities considered poverty, criminality, and “feeblemindedness” all to be heritable.\textsuperscript{15}

What is more, many argued that these traits were disproportionately prevalent in immigrant communities who had found work within America’s growing industrial workforce and resided in urban centers. Of course, these claims during the eugenic period failed to tease out and take into account factors like limited public education in cities, inadequate public health and sanitation efforts, and general failures to allocate significant public resources for


\textsuperscript{14} Alfred Kinsey, Paul Gebhard, & Wardell Pomeroy, Sexual Behavior in the Human Female (1953); Alfred Kinsey, Paul Gebhard, & Wardell Pomeroy, Sexual Behavior in the Human Male (1948).

\textsuperscript{15} See, e.g., Buck v. Bell 274 U.S. 200 (1927) (finding Carry Buck to be mentally impaired, concluding this impairment was inherited, and therefore authorizing her involuntary sterilization).
the care of the indigent. In short, the xenophobic fears that vamped up during the Gilded Age and Progressive Era would be confirmed by a range of eugenic claims about science and statistics, establishing for many in the early twentieth century that racial minorities were scourges causative of a range of social ills. Anti-immigration laws like the Chinese Exclusion Act would be followed by more robust quotas like the Emergency Quota Act, and would be further developed and refined in courts. For example, ever since 1923, the Supreme Court had made clear that people from India—regardless of their skin color—are not white.16 Bans on people immigrating to the U.S. from China, India, and numerous other countries would remain in effect until the mid-1960s. So too would anti-miscegenation laws in numerous states until 1967.17 Thus, middle and upper-class native whites were the ones in the first half of the century who actually stood a chance at winning the “fitter family” contests that took place in state and county fairs across the country, while immigrants (or at least those of certain skin colors) were prohibited from marrying into and thereby tainting or diluting the native population’s germline.

Alongside new discussions of heredity, contraception and sterilization would also thoroughly enter the public arena in the first half of the twentieth century, especially through the work of first-wave feminists like Margaret Sanger and Mary Ware Dennett. Granted, Sanger and the American Birth Control League did tailor much of their efforts towards expanding contraception access to low-income individuals. However, while these efforts would be foundational in the history of tending to the reproductive interests of marginalized individuals, they are contextualized by the fact that Sanger and many within first-wave feminism were ready supporters of using birth control to promote the aims of the eugenics movement.18

In lamenting that “these foreigners who have come in hordes have brought with them their ignorance of hygiene and modern ways of living and that they are handicapped by religious superstitions is only too true,”19 Sanger defended a neo-Malthusian rationale for expanding access to reproductive tools to indigent immigrants. It is hard to deny that one

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18 Margaret Sanger, Woman and the New Race (1920); Margaret Sanger, The Eugenic Value of Birth Control Propaganda, Birth Control Rev. 5 (1921); Margaret Sanger, The Pivot of Civilization (1922).
19 Sanger, Woman and the New Race, supra note 18 at 11.
foreseeable result of expanding access to contraception is that it would encourage immigrants to have fewer children. This would allay the worries of people like the 1891 treatise writer who warned that immigrants imminently threatened to “possess New England” because natives were using contraception and abortion, thus failing to keep up their ranks.  

However, as with the value that Sanger saw in contraception for women generally, she took expanding access to indigent immigrants as a national salve, a morally incumbent duty rooted in the nation’s history of poor treatment towards this group:

> The cell plasms of these peoples are freighted with the potentialities of the best in Old World civilization. They come from lands rich in the traditions of courage, of art, music, letters, science and philosophy. …[yet we] have herded them into slums to become diseased, to become social burdens or to die. We have huddled them together like rabbits to multiply their numbers and their misery. Instead of saying that we Americanize them, we should confess that we animalize them. The only freedom we seem to have given them is the freedom to make heavier and more secure their chains. What hope is there for racial progress in this human material, treated more carelessly and brutally than the cheapest factory product?  

Thus, on one side of the coin was the value of expanding access to reproductive tools, while the flipside was that this was a form of negative reproductive selection carrying a eugenic overtone: it was “compassionate” to make these reproductive tools available to the poor because—à la Thomas Malthus—birth control would encourage lower classes to limit reproduction and thereby reduce the likelihood of passing on characteristics like poverty, criminality, and feeblemindedness to their offspring.

The litigation pursued by members of the birth control movement during this time led to successes in expanding access to reproductive tools, with circuit courts beginning by the 1930s to permit the distribution of contraception so long as it was prescribed by a doctor.  

Such legal victories thus began to challenge Comstock laws, laws that were increasingly proving to be outmoded relics protecting the sexual morals of an earlier age. Medical malpractice litigation also evidenced this same transition in social mores regarding

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20 Sinclair, supra note 12.

21 Sanger, Woman and the New Race, supra note 18 at 12.

22 United States of America v. One Package of Japanese Pessaries, 86 F.2d 737 (2d Cir. 1936).
contraception in the first half of the century. Again, what this revealed was that those with financial and social access to regular physicians were the ones who could opt for a growing array of doctor-recommended sterilization and contraceptive options rather than only those freely available at birth control clinics.

Those who did have access to regular physicians were already bringing claims over botched sterilization procedures by the 1930s, with such breach-of-contract cases showing not just that people were using sterilization for family-planning purposes, but also revealing how reproductive rights started to emerge as they were enforced and created in court. In *Christensen v. Thornby*, for example, the trial court had found the contract to perform a vasectomy at issue “was against public policy and for that reason void.” Making clear that it did not endorse broader uses of voluntary sterilization, the Minnesota Supreme Court in *Thornby* chose to honor the contract on the grounds that it was medically indicated, for the couple had used the vasectomy to prevent a subsequent high-risk pregnancy. This could be seen as a continuation of courts and doctors making an exception to bans on reproductive tools for the purposes of protecting a pregnant woman’s life and health interests. This medical-necessity rationale given by the court also implicitly condoned couples who continued sexual activity after sterilization, i.e., for reasons other than procreation—it was thus an early judicial voice in approving of the use of reproductive tools for the purposes of pleasure and intimacy. The *Thornby* decision came at a time when half a dozen state legislatures explicitly articulated that any contract to perform a non-medically indicated, voluntary vasectomy (i.e., one for family planning purposes) was unenforceable in courts for being contrary to public policy.

II. Reproductive Tools by the Midcentury: Fundamental Rights or Entitlements?

After the Second World War, the possibilities offered by reproductive technologies continued to expand with developments in contraception like the Pill, voluntary sterilization

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23 *Christensen v. Thornby*, 255 N.W. 620, 621 (Minn. 1934).

24 *Id.* at 621.

25 *Id.*
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procedures like tubal ligations, and new uses of prenatal technologies like amniocentesis. Civil litigation also continued over access to contraception, with many cases involving a new inflection after President Truman signed the Hill-Burton Act into law as part of the Public Health Service Act, with the goal of stimulating construction, renovation, and other improvements to the nation’s infrastructure of hospitals.\(^{26}\) These federal funds were the first to be designated to tackle a similar issue that would later emerge under programs and laws like Title X and EMTALA: funding the medical treatment and care of low-income, uninsured pregnant women. One fact pattern that emerged in multiple instances of hospitals receiving Hill-Burton funds was that religious individuals and institutions would refuse to perform sterilizations when patients asked for them out of reasons other than medical necessity. In some cases, this involved refusing the wishes of a welfare recipient to have such a procedure performed immediately after her delivery.\(^{27}\)

By the mid-twentieth century, sterilization and contraception had undeniably become ubiquitous practices. For example, while Kansas, Kentucky, Utah, and Texas still banned nontherapeutic vasectomies in 1958,\(^{28}\) by 1965, roughly 13 percent of all married couples nationally had undergone sterilization for contraceptive purposes—a number which grew to 18 percent by 1970 and about 29 percent by 1973. By 1975, roughly 7.9 million Americans had chosen sterilization, which had become the most popular method of contraception chosen by married couples.\(^{29}\) Thus, from vasectomy cases at the state level like *Thornby* to contraception cases reaching federal circuit courts like *One Package of Pessaries*, medical necessity was a jurisprudential “wedge” that initially enabled more couples to rely on voluntary sterilization or contraception for any reason (i.e., rather than only medical necessity) and enforce their rights to do so in court, even before the constitutional right to contraception had been recognized. Just as the exception for “life” interests in anti-abortion statutes before *Roe* opened a door for greater on-demand access to abortion, these


discretionary medical-legal standards primarily benefited those having two forms of access: access to trained physicians offering safer abortion and sterilization procedures, and access to courts.\(^{30}\)

Expanding upon this initial wedge, *Griswold* made the first departure at the level of the Supreme Court from the Victorian federal reproductive policy evidenced in Comstock laws, by recognizing that only married couples had constitutional rights to use contraceptive options. It described the right to contraception as existing within a broader privacy right, found to exist within the “emanations” and “penumbras” of the Constitution.\(^{31}\) It thus connected threads of the Court’s substantive due process doctrine—that is, its line of precedent carving out of certain rights as so fundamental and basic that they should not be subject to governmental interference (unless the government can establish its interest is compelling), even though such a right is not explicitly mentioned in the Constitution. The Fourteenth Amendment had already been found to encompass a right to privacy in family planning choices like how one raises one’s children.\(^{32}\) The Court’s substantive due process doctrine had also expressed—without overturning *Buck v. Bell*’s holding that the Constitution does not prohibit involuntary sterilization—that the “the right to have offspring” is “one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race.”\(^{33}\) *Griswold* further expanded upon these notions of a right to non-interference in one’s family planning choices, adding to them the freedom to use reproductive tools to choose whether or not to have a family at all—that is, by granting married couples the freedom to access contraception.

\(^{30}\) It should be noted that access to regular physicians would not necessarily have been associated with safer sterilization, abortion, and childbirth in the early-to-mid twentieth century. In these contexts prior to the professional standardization of antiseptic techniques in the U.S., risk of death from infections like puerperal fever was actually greater among the clientele of regular physicians—who often saw multiple patients each day and could consequently transmit germs, than the clientele of alterative practitioners like midwives—who typically attended to only one patient in a day. See, e.g., Irvine Loudon, *Death in Childbirth: an International Study of Maternal Care and Maternal Mortality 1800–1950* (1992).


\(^{32}\) *Pierce v. Soc’y of Sisters*, 268 U.S. 510, 534 (1925) (finding law requiring children’s attendance at public schools unconstitutionally violated parental rights to “direct the upbringing” of their children); *Meier v. Nebraska*, 262 U.S. 390, 400 (1923) (finding a law restricting foreign language education to violate parents’ rights to choose their children’s education, a right protected by the Due Process Clause of the Fourteenth Amendment).

For a brief period, given that anti-miscegenation laws were constitutional at the time, this constitutional right to contraception would have been restrictive for many immigrants: unless they were from the “right” parts of Europe, then they were presumptively people of color, and a person of color (whether immigrant or native) had a restricted right to marry across the country. In addition to Supreme Court precedent articulating which immigrant groups would and would not be considered “white,” states made their own laws restricting marriages between whites and “Negroes and Mulattoes,” as well as white marriages with “Mongolians” (a term applying to Chinese, Japanese, and Koreans), “Malays” (Filipinos), “Hindus” (South Asians), and other categories. Among the other achievements of the 1960s in the realm of civil rights, Loving v. Virginia was an important step in protecting the reproductive rights of immigrants by reinforcing the dicta of Skinner v. Oklahoma that “Marriage is one of the ‘basic civil rights of man,’ fundamental to our existence and survival.” In that holding two years after Griswold, the Court explained that “[t]o deny this fundamental freedom on so unsupportable a basis as the racial classifications embodied in these statutes, classifications so directly subversive of the principle of equality at the heart of the Fourteenth Amendment, is surely to deprive all the State’s citizens of liberty without due process of law.”

On the one hand, the framework of Supreme Court reproductive policy begun in Griswold was rooted in the generally accepted social and moral goal of recognizing marital

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34 Wyo. Rev. Stat Ann. § 68-118 (1931) (“All marriages of white persons with Negroes, Mulattoes, Mongolians, or Malays hereafter contracted in the state of Wyoming are and shall be illegal and void.”).


40 Id.
privacy as a fundamental, basic right, “a right of privacy older than the Bill of Rights—older than our political parties, older than our school system. Marriage is a coming together for better or for worse, hopefully enduring, and intimate to the degree of being sacred.”\textsuperscript{41} In recognizing the right of only married couples to access contraception, the social policy that the Court established could be justified on the grounds that it promoted sexual intimacy between married people, and also on the grounds that it supported greater equality for women in the context of labor and employment—as contraceptives and voluntary sterilization enabled women and men greater control over major life choices like the timing of pregnancy in one’s career, how many children one wants, or whether to have children at all.

On the other, \textit{Griswold} operated as a further jurisprudential wedge in jettisoning Victorian sexual morality in favor of the values of the postwar sexual revolution. Less than a decade after that ruling, the Court updated the federal position on contraception in the same year it decided \textit{Roe}, finding that the Constitution also extended the contraception right to all citizens, whether married or single.\textsuperscript{42} In \textit{Eisenstadt v. Baird}, the Court found that it would violate the Equal Protection Clause if the fundamental rights of \textit{Griswold} were not also extended to single people. In this respect, these cases established what this article describes as the “on-demand” or “pay-to-play” character of the Court’s reproductive policy. Contraceptive options had become a fundamental right—at first in \textit{Griswold} only understood as fundamental by virtue of being within the marriage relationship (thus, notably, immigrants and people of color were more restricted in exercising this right), and then in \textit{Eisenstadt} and several other cases it came to be understood as fundamental for all citizens, regardless of whether they are married, regardless of their skin color and ethnicity, a right extending to those well below the legal age of majority.

While an unfettered right to access contraception in these ways gradually came to be extended to all citizens, the creation of that right fell within the Court’s substantive due process doctrine, which creates rights in terms of civil liberties to be free from non-interference. By recognizing the constitutional right to contraception as one of non-interference, the Court thus ensured that those who had sufficient financial means could \textit{not be denied access} to these tools, but it did not similarly extend such assurance to those without


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the ability to pay. Soon after the right to contraception had been granted, indigent petitioners would ask courts whether this constitutional right to contraception, under welfare laws like Social Security, included vasectomies for the poor. The resounding answer would be in the negative. This would also be true of tubal ligations; one of several cases, for instance, seeking to compel religious hospitals receiving Hill-Burton funds to perform a tubal ligation involved “an unwed mother of two children, [who] is a welfare recipient and is subject to epileptic seizures.” The federal district court in that case would consider whether the new constitutional right to contraception extended to the petitioner’s case and concluded that it did not, finding that the religious hospital’s refusal did not endanger the plaintiff’s life and health. The federal jurisprudence of reproductive rights would thus purport that reproductive rights are foundational, basic rights, but in practice would permit them to be denied to the least advantaged members of society.

Roe v. Wade entrenched this bifurcated nature of reproductive rights even further, through the expansive language it used to define the abortion right, and through the legal and political backlash to which it foreseeably led. In its reproductive policy articulated in Roe, Casey, and their progeny, the Court made clear that the constitutional right to abortion is not just a privacy or bodily integrity right but also a fundamental liberty and autonomy right guaranteed by the Due Process Clause. In describing the interests protected by the abortion right, the Court explained that the determination of whether to continue a pregnancy or terminate it is a “choice central to personal dignity and autonomy, [and one] central to the liberty protected by the Fourteenth Amendment.” More specifically, the Court has articulated that this liberty should be understood as a woman’s right to “determine her life course” and exercise “control over her destiny” by being able to have her pregnancy terminated. This component of the Court’s reproductive policy jurisprudence—defining abortion as a liberty and autonomy right—helped institutionalize reproductive tools qua women’s employment rights, that is, as mechanisms for promoting greater gender equality.

47 Casey, 505 U.S., at 869.
in the workplace by giving women greater control over how to determine their lives, family planning, and employment choices.

These facets of how reproductive policy has defined itself show its “pay-to-play” nature: rights to reproductive tools are non-interference rights that prevent the government from taking actions that impose restrictions or prohibitions on these rights; they are not fundamental or basic in the sense of requiring the federal government or states to take actions to secure them. Given the dedication of resources to contraception and prenatal care under Title X, the Supplemental Nutrition Assistance Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and other federal programs, the federal position saps much of the pay-to-play aspect out of access to contraception. Still, Title X, SNAP, and WIC all only extend coverage to those meeting the requirements to be considered “qualified” noncitizens.

Further, the constitutional right to contraception created an “on-demand” right because the Court recognized that people have the right to access it for any reason or no reason whatsoever, rather than only in cases of medical necessity, as with the holdings in Thornby and One Package of Pessaries. Notwithstanding the many regulations of abortion after Roe—this time not by the physicians of the AMA evangelizing the new science of embryology, but rather actions by politically mobilized religious groups—the Court’s jurisprudence of abortion as a liberty and autonomy right that extended through childbirth thereby defined abortion similarly to be accessible for any reason, that is, accessible on-demand rather than only in cases of medical necessity.

To understand this point, consider how medical necessity fit within (or was omitted from) the trimester framework that Roe instituted. In the first trimester (when virtually all abortions occur), a state was prohibited from imposing any regulations on abortion—the risks associated with abortion at that point in pregnancy were lower than those associated with childbirth, thus the Court reasoned that states could not have compelling interests in restricting the abortion right in the interests of a woman’s life or health. During the second tier of this framework, that is, from the end of the first trimester until the point of viability (which the Court placed near the end of the second trimester), states can assert a compelling interest in abortion regulations in the interest of women’s health, but not regulations protective of fetal life. Finally, only in the third trimester could a state’s interests in fetal life become compelling, such that it could ban abortion so long as the law contained exceptions.
As mentioned, in terms of judicial review, this compelling interest must be established whenever a challenged government action infringes on a fundamental right. A government action infringing on a fundamental right triggers strict scrutiny analysis.

Of central importance, any state’s ban on abortions must contain exceptions for women’s “health” interests, with the Court specifying the definition of health in *Doe v. Bolton*, the companion case to *Roe* that the Court published on the same day. The meaning of health in the health exception was to be a broad one, the Court explained, that should be assessed “in light of all factors—physical, emotional, psychological, familial, and the woman’s age—relevant to the wellbeing of the patient.” Even when the abortion right was given serious reconsideration two decades later in *Casey*, this health exception remained intact, though it fell within *Casey*’s undue-burden analysis instead of *Roe*’s trimester framework. *Casey* still prohibited states from banning abortions prior to fetal viability and still required the health exception after viability. The only ban to date that has been upheld as constitutional came in 2007, when the Court upheld a law that banned the use of only one particular type of “partial-birth” abortion procedure (a political, rather than medical term). With the exception of that singular procedure, therefore, the Court has made clear that abortion can never be prohibited for any reason at any point during pregnancy, because it will virtually always be in the broadly defined physical, emotional, and psychological interests of a pregnant woman not to be denied an abortion when she is seeking one. This exemplifies how the jurisprudence creating the right to abortion, in addition to the right to contraception, carved those reproductive rights out as pay-to-play, on-demand rights.

While the terms of *Griswold*, *Eisenstadt*, *Roe* and their progeny were generous for those with financial means, this was less the case for the indigent. Rather, the Hyde Amendment, a legislative provision passed in 1976 that has remained in effect every year since then, prohibits the use of federal funding like Medicaid on abortions. The Hyde Amendment does not include the health exception requirement, i.e., an essential aspect of the on-demand scope of the abortion right, but it does include exceptions for the woman’s life, as well as for cases of incest and rape. The indigent fared better on the front of contraception, which was less politically controversial, from efforts including President Lyndon Johnson’s “War

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49 *Gonzales*, 550 U.S. 124.
on Poverty” to Title X of the Public Health Service Act. Since 1970, Title X has remained the only federal grant program dedicated solely to providing family planning tools other than abortion to low-income and uninsured people, through grant funding available to clinics, health centers, hospitals, faith-based organizations, and other actors that allocate their resources towards targeting these populations.

If the social forces leading to *Roe* had been focused on low-income, non-native, immigrant, or minority populations, the Supreme Court’s institutionalization at the federal level of what is today’s reproductive policy perhaps would have focused more on making such options available to those populations. It might have recognized abortion only as a constitutional right in exigent circumstances, even a positive right that imposed an obligation under welfare programs in cases of exigency. Rather than tending to the needs of comparatively disadvantaged groups like the indigent or immigrants, however, the Court instead defined abortion in such a way as to secure the interests of the middle and upper-class, and the native born. Yet the brief historical sketch provided in this and the previous section has noted that these were groups who already held a comparatively privileged status in the growing domain of reproductive policy throughout the twentieth century.

It is this highly unequal terrain that continues into the present—an infrastructure of reproductive policy that helps the privileged reinforce their privilege by affording them greater control and rights over the future generations they create. In doing so, the effects of the Court’s rulings in many ways buttress the disadvantages that the least advantaged members of society already bear, putting them at a greater disadvantage in the present and in future generations. In sum, inasmuch as reproductive tools had taken on this new shape from the mid-twentieth century onwards, so also were the disadvantages faced by the indigent and noncitizens magnified.

### III. Noncitizen Reproductive Rights and Documentation

As the previous section highlighted, reproductive rights by the mid to late-twentieth century had come to be recognized as fundamental rights, rights basic to personal dignity, wellbeing, and freedom. On the one hand, this meant any regulations infringing on these rights would be subject to strict scrutiny. On the other, the idea that a reproductive tool like
abortion is a “fundamental” right continues to be morally and politically contested on the national and global stage, though it has been relatively settled as a matter of constitutional law in the U.S.

In a recent national Gallup poll, for example, between the choices of “legal under any circumstances,” “legal only under certain circumstances,” and “illegal in all circumstances” (emphasis mine), 50% of survey respondents believed abortion should fall under the legal only under certain circumstances category. The majority of respondents have always identified with this category in Gallup surveys. In this survey, between choosing whether “certain circumstances” should apply to most circumstances or only a few, by a more than a 3-1 ratio, people expressed it should only extend to a few circumstances.\(^\text{50}\)

Additionally, Ireland has only in 2018 changed its policy under which abortion was presumptively illegal. Even with this comparatively late adoption for a country in Western Europe of a legal policy permitting abortion, it continues to be presumptively illegal in most of South America, Africa, and Asia. Abortion is “fundamental” in the U.S. as a matter of constitutional law and principles of judicial review, but the concept of a fundamental right also notably appeared in the postwar period in the Universal Declaration of Human Rights (UDHR). However, while it has some greater traction in international law, abortion has never been one of the fundamental rights articulated in the UDHR—it has never been fundamental in the same sense as the right to be free from torture, for instance. Contraception continues to maintain a less controversial status, though it continues to be a contested issue in arenas like public sex education and financing family planning aid in foreign countries.

In contrast to fully alien or foreign people, take “noncitizens” as shorthand for referring to those who are in the U.S. and desire to remain there for an indefinite period, but are not citizens by virtue of lacking some necessary form of documentation. This documentation might be a photo-ID issued by a state government, the Form I-485 needed to apply for lawful permanent residence, or the Forms I-821D, I-765, and I-766 that have been required under the DACA application process. In the context of reproductive rights, this section argues that people lacking this documentation can resultantly be impeded in exercising reproductive rights because of their lack of citizenship.

It should be apparent initially that noncitizens do possess some constitutional rights. The

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Fourteenth Amendment states that no state “shall . . . deprive any person of life, liberty, or property, without due process of law; nor to deny any person within its jurisdiction equal protection of the laws” (emphasis mine).\(^\text{51}\) The Supreme Court has recognized that people unlawfully in the U.S. have due process rights under the Fourteenth Amendment,\(^\text{52}\) as well as all constitutional rights related to criminal charges.\(^\text{53}\) While discussions about the constitutional protections available to noncitizens have focused almost entirely on procedural rights related to criminal charges, border crossing, detainment, deportation, and similar issues,\(^\text{54}\) it has remained less clear whether noncitizens do or should have substantive due process rights like contraception and abortion. Initially, it seems likely that a noncitizen with enough money could find an abortion provider or the right contraceptive options—so perhaps it is sufficient merely to be within U.S. borders to assert constitutional rights to contraception and abortion.

But for those noncitizens who are indigent, their lack of citizenship places them in a more disadvantaged position with respect to accessing reproductive tools than others who are indigent but possess citizenship status. Compare indigent noncitizens, for example, with citizens receiving Medicaid. Medicaid recipients in every state possess more reproductive rights than noncitizens. In terms of abortion access, the majority of states allocate their Medicaid funds towards providing “medically necessary” abortions.\(^\text{55}\) In the many other states that chose to restrict access, though, Medicaid funds are only permitted to be used in

\(^{51}\) U.S. Const. amend XIV, sec. 1.

\(^{52}\) Zadvydas v. Davis, 544 U.S. 678 (2001) (finding the Fourteenth Amendment’s guarantee of due process extends to those whose presence in the country may be “unlawful, involuntary, or transitory”).

\(^{53}\) Almeida-Sanchez v. United States, 413 U.S. 266 (1973) (recognizing noncitizens possess such rights under the First, Fourth, Fifth, Sixth, and Fourteenth Amendments).


instances of rape, incest, or life endangerment to the mother. In terms of contraception, the Maternal and Infant Health Initiative of the Center for Medicaid and CHIP Services actively promotes access to contraception, and encourages each state to use Section 1115 waivers and other methods to take a multidimensional, broad approach towards providing contraception to Medicaid recipients. Finally, all states include some range of standard prenatal and postnatal care for pregnant women on Medicaid, thus giving many Medicaid recipients access to reproductive technologies.

A broader picture is needed to understand the relevant terrain of reproductive rights. For those with financial means, reproductive rights can often be asserted long before a pregnancy has begun. Thus, it is essential to note how private litigation—most relevantly in tort, but also in breach-of-contract cases like *Thornby*—is an expansive domain in which reproductive rights are defended, imagined, and created. It is also important to highlight that the rise of actions like wrongful life, wrongful conception, and wrongful birth claims was in large part a function of technological and scientific discoveries into the nature of genetics and disease: discoveries in genetics and technological advances from the 1950s to the 1980s would be followed by a surge in clinical malpractice claims stemming from the use of reproductive technologies. Because of the rise of malpractice litigation for genetic and other types of congenital disease, reproductive rights have come to encompass not just the availability of contraception and abortion, but also a right to exercise those rights in an informed matter by utilizing reproductive technologies like ultrasonography, amniocentesis, chorionic villus sampling, *in vitro* fertilization, and preimplantation genetic diagnosis.

Inasmuch as access to reproductive tools continues to expand to encompass such technologies, so also do the disadvantages faced by the indigent and noncitizens risk being magnified. Contemporary discussions that emerge with the rise of new reproductive technologies and discoveries that have the potential to transform healthcare practice and society—from nanotechnology, to clinical applications of genomics, to promising new frontiers in gene editing using CRISPR-Cas9—remain important. Technologies like these can bring therapeutic advances to all stages of life, from prenatal diagnosis, to early pediatric interventions, to end-of-life care. Technological advances are perhaps felt most palpably when they affect reproductive bodies—because of the ways in which they can shape and

56 *Id.*
change the lives of present people, because of the potential that reproductive technologies hold to shape and constitute the characteristics of future generations that present people create, and also because of the distributional and societal inequities they can thereby exacerbate. They are biopolitical tools *par excellence*.

For those with access to courts, the emergence of these biopolitical technologies in many states has resulted in new judicially created reproductive rights to make informed contraception and abortion decisions, unimpeded by clinicians. A number of states declare that these rights sounding in informed consent are fundamental rights protected by *Griswold*, *Roe*, and other Supreme Court cases of their ilk. The facts of one wrongful birth-wrongful life case, for instance, involved a doctor who received alpha-fetoprotein (AFP) testing results indicating the high likelihood that a patient’s fetus would be born with Down syndrome. Instead of informing the patient of these results, the doctor chose to have an ultrasound ordered—which he knew would not reveal this aneuploidy at her present stage of pregnancy—and then only returned the ultrasound results, concealing the AFP results until it was no longer legal for the patient to obtain an abortion. The patient’s child was born with Down syndrome, and “[d]iscovery of Defendant’s office staff revealed that the Defendant had a firm policy against abortion in his office.”[^67] The case settled for $887,500.

Other cases make clear that reproductive rights can begin long before conception. In one wrongful conception-wrongful life case, a provider negligently administered an Rh-negative blood transfusion to a thirteen-year-old girl whose blood type was Rh-positive. The litigation did not arise until she was an adult and gave birth to her first child, who was born with hyperbilirubinemia and severe, permanent neurological and physiological damage because of the improper transfusion nearly a decade before the infant plaintiff was born.[^68]

The growth of reproductive technology-related litigation reveals both the expanse of reproductive rights and also highlights how these rights are only available to those possessing the financial means and citizenship status to carve out reproductive rights for themselves in court. With this understanding in hand of the expansive, technology-driven domain of reproductive rights that has emerged in the U.S. via litigation over reproductive technologies, it becomes clearer why those with financial means, as well as citizens with limited financial


means, have standing to exercise and enforce their reproductive rights in court in a way that indigent noncitizens cannot.

By contrast to indigent citizens and citizens with financial means, an indigent noncitizen would have scarce reproductive rights. Currently, a pregnant woman in labor who is undocumented has only limited federal protections. As mentioned in the previous Section, Hill-Burton grants were an important initial infrastructure towards this end in 1946. EMTALA was the next major step, first emerging as part of the Consolidated Omnibus Budget Reconciliation Act of 1986. By that time, there was substantial evidence that hospitals were discriminating against potential patients, refusing to treat the indigent and insured.\(^{59}\) In many instances, this resulted in people dying outside of hospitals for lack of care.\(^{60}\) EMTALA’s prohibition of “patient dumping” has been important in reforming how hospitals and emergency rooms are required to treat the indigent, uninsured, and undocumented, but EMTALA only applies to those institutions receiving federal funding. Further, EMTALA only requires that federally-funded healthcare providers ensure that their emergency rooms determine whether the patient presents an “emergency medical condition,” stabilize the person if such an emergency medical condition exists, or else transfer the patient to another hospital that can provide stabilization.\(^{61}\)

Interpretations of the EMTALA statute by judges and administrative agencies have established the precedent that labor and delivery constitutes an emergency medical condition if contractions have ensued.\(^{62}\) However, given the realities of false positives, limited attending physicians in emergency departments, and misdiagnosis of pregnancy-related issues, disputes have arisen as to whether or not an indigent, uninsured plaintiff should fall under EMTALA’s protections. In \textit{Williamson v. Roth}, a pregnant woman complained to an emergency room nurse of abdominal pain but was discharged before this order had


\(^{61}\) 42 U.S.C. § 1395dd(a).

\(^{62}\) 42 U.S.C. § 1395dd; 42 C.F.R. § 489.24(b)(1) (defining “labor” under EMTALA as “childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta”).
been given by the attending obstetrician; after she returned several hours later with vaginal bleeding, an ultrasound was ordered which confirmed fetal demise.\textsuperscript{63} The court in \textit{Williamson} allowed her to continue with her suit under EMTALA. In other cases, no adverse outcome was necessary. In \textit{Owens v. Nacogdoches County Hospital}, for instance, an uninsured pregnant woman experiencing contractions sought care at a local emergency department but was instructed to drive to another hospital. Though both she and the child born were unharmed, the court found EMTALA had been violated because the hospital did not provide a vehicle, as guaranteed under the transfer requirement of the statute, but rather had directed her to travel in her boyfriend’s car.\textsuperscript{64}

Under EMTALA, therefore, a hospital receiving federal funds is required to do little more than perform the delivery or stabilize and transfer. If the delivery presents complications, EMTALA might further encompass some range of ancillary services, like a cesarean section, but probably not others, like many treatments for congenital diseases. The specific wording of the statute extends only to pregnant women and the unborn. Professional recommendations have suggested that EMTALA should extend to aspects of prenatal care including assessments of viability and fetal heart rate monitoring if fetal movement decreases, four hours of fetal surveillance if a pregnant woman has received a direct impact to her abdomen, and intrauterine resuscitation when fetal bradycardia or tachycardia is detected.\textsuperscript{65}

While its protections extend to pregnant women and the unborn, EMTALA does not expressly grant any rights to newborn infants, unless they demonstrate an emergency medical condition independently falling under the statute. Granted, institutions that provide newborn screening do so regardless of the person’s health insurance, immigration status, or ability to pay. However, this is undeniably justified with reference to the benefits of collecting data for clinical research and public health—there are no guarantees, for example, that an undocumented pregnant woman relying on EMTALA would have a right to have the results returned from such newborn screening, much less access to treatments for a range of serious

\textsuperscript{63} \textit{Williamson v. Roth}, 120 F. Supp. 2d 1327 (M.D. Fla. 2000).


congenital conditions that do not pose an immediate emergency. Rather, there are little to no assurances under EMTALA regarding access to highly effective treatments for non-severe congenital diseases, which can still leave the newborn child with lifelong debilitating health consequences if left untreated.

Access to reproductive technologies and prenatal care might also be available to noncitizens through “disproportionate share hospitals” (typically teaching hospitals and hospitals in large urban areas), as well as other clinics, health centers, and non-profits given partial compensation for services through Medicare funding by the Health Resources and Services Administration to provide access to uninsured, Medicaid, and undocumented patients. In addition to receiving Medicaid funding indirectly in this way via access to safety net hospitals, access to prenatal care might be available directly under Medicaid—namely, if the person is a lawful permanent resident (LPR), or if the person is giving birth in one of the minority of states that allocates Medicaid funds towards prenatal care for uninsured, indigent, or undocumented individuals. Further, “qualified” noncitizens including LPRs and others described below might be able to receive disability-related coverage for congenitally impaired neonates under Supplemental Security Income benefits, or under Social Security Disability Insurance for those noncitizens with work situations enabling them to receive a Social Security card.

Reproductive rights have demonstrated themselves to be something that must be asserted—whether by paying for contraception, abortion, and reproductive technologies, or by filing malpractice actions when clinical actors inhibit one’s abilities to use those reproductive tools. Many people can assert these rights with assistance from their own finances, their employer-provided health insurance, and in many states, with the assurance that a variety of actions rooted in reproductive technologies are available to them in cases of medical malpractice. Again, even affluent noncitizens would be cut off from this last possibility of asserting reproductive rights in court, because they lack standing to sue and thus lack a crucial protection against medical malpractice when disputes arise over clinical use of reproductive technologies. Damages in these cases might seek not only the pain and suffering and medical costs associated with labor and delivery, specific actions also permit parents to seek compensation for the cost of raising a congenitally impaired child that they

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otherwise would have avoided having (i.e., by relying on contraception or abortion) to adulthood. The ability to exercise these reproductive rights in court through such actions, in other words, could hold a value not just in the six or seven figures, but in many cases even into eight-figure awards.\footnote{E.g., Carol M. Ostrom, \textit{S50M Awarded over Birth Defect; Test Said Baby Would Be OK}, SEATTLE TIMES (Dec. 10, 2013); see also Luke Haqq, Note, \textit{Of Mosquitoes, Adolescents, and Reproductive Rights: Public Health and Reproductive Risks in a Genomic Age}, 101 MINN. L. REV. 827, 846–47 (2016).}

Noncitizens can be further disadvantaged by lacking documentation not explicitly required by state or federal law. For example, a valid driver’s license or government-issued ID is often a prerequisite at clinics performing abortions like Planned Parenthood.\footnote{E.g., \textit{Abortion Day Checklist}, PLANNED PARENTHOOD, https://www.plannedparenthood.org/files/4614/0085/3549/AB_Day_Checklist__07_13.PDF; \textit{Instructions for In-Clinic Abortion}, PLANNED PARENTHOOD OF MARYLAND, https://www.plannedparenthood.org/planned-parenthood-maryland/client-resources/abortion-services/in-clinic-abortion-procedure; \textit{Teens Seeking Abortion Services}, PLANNED PARENTHOOD OF SOUTH, EAST, AND NORTH FLORIDA, https://www.plannedparenthood.org/planned-parenthood-south-east-north-florida/for-patients/teens-seeking-abortion-services; \textit{Fees for Services}, PLANNED PARENTHOOD OF WESTERN PENNSYLVANIA, https://www.plannedparenthood.org/planned-parenthood-western-pennsylvania/patients/fees-services.} This is but one of many ways in which noncitizens can be denied access because they lack specific documentation—often a state government-issued photo ID. The protections embodied in Development, Relief, and Education for Alien Minors (DREAM) Act legislation, and Obama administration policy from 2011 onwards in what became the DACA program,\footnote{Memorandum from John Morton, Director, U.S. Immigration and Customs Enforcement (June 17, 2011), https://www.ice.gov/doclib/secure-communities/pdf/prosecutorial-discretion-memo.pdf; see also Memorandum from Janet Napolitano, Secretary of Homeland Security (June 15, 2012), https://www.dhs.gov/xlibrary/assets/s1-exercising-prosecutorial-discretion-individuals-who-came-to-us-as-children.pdf.} have been foundational in promoting noncitizen reproductive rights by improving access to photo IDs. The Act and executive actions were not about reproduction, but the interests they sought to protect—such as the ability to obtain employment, a college education, and a driver’s license—are factors that can fundamentally affect the ability of noncitizens to exercise and assert reproductive rights. Noncitizens with employment might be able to access contraceptive options through their employer-provided health insurance, while a person with a valid driver’s license would meet the ID requirements at clinics like Planned Parenthood. In addition to DACA’s assistance in transitioning younger people from noncitizenship to citizenship, roughly a dozen states also assist in the process to documentation by permitting undocumented people to obtain driver’s licenses. Even with such requisite identification,
indigent noncitizens would still face the obstacle of financing abortion. In such cases, some abortion providers offer subsidization options funded by private donors for indigent clientele who cannot afford the procedure.\textsuperscript{70}

Finally, in addition to factors like ability to pay and government-issued ID requirements, I have mentioned that Medicaid coverage may be available to some noncitizens. For a noncitizen to benefit directly from Medicaid, the person must be an LPR or other qualified noncitizen. Also known as a green-card holder, an LPR has been given authorization to live and work in the U.S. on a permanent basis. There are two ways to become an LPR, depending on whether one is abroad or in the U.S. during the application. If the applicant is outside the U.S., the process involves obtaining an immigrant visa through a Department of State consular office and applying for LPR status at port of entry. The second way to become an LPR is available to eligible individuals residing in the U.S.—namely, to “qualified” noncitizen categories like refugees, asylees, certain temporary workers, and family members of citizens or LPRs. Such qualified noncitizens must file Form I-485, “Application to Register Permanent Residence or Adjust Status” with U.S. Citizenship and Immigration Services. Such individuals can apply to work while their Form I-485 application is pending,\textsuperscript{71} with employment possibly including Social Security and health-insurance benefits. Of the 3,058,102 total LPR statuses that were granted from 2013 to 2015, 46–49% annually were obtained via the first process, while 51–54% were obtained using the second.\textsuperscript{72} Preference for LPR status is given to cases of family sponsorship, employer sponsorship, immigrants from countries with low immigration rates to the U.S., and to refugees and asylees.\textsuperscript{73}

If one is or becomes an LPR as described above, then the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) permits some LPRs to apply for Medicaid—namely, pregnant women who are LPRs but have not reached the five-year point when naturalization becomes possible. Prior to CHIPRA, pregnant LPR women could apply for Medicaid under the Personal Responsibility and Work Opportunity Reconciliation Act of


\textsuperscript{72} Id. at 1.

\textsuperscript{73} 8 U.S.C. § 1153.
1996. This exception that allows LPRs to gain direct access to Medicaid coverage prior to naturalization also applies to Cuban and Haitian entrants, battered spouses and their children, victims of trafficking, those with humanitarian statuses (e.g., Temporary Protected Status, Special Juvenile Status), and those covered under special legislation (e.g., LIFE Act and Family Unity noncitizens).

Once an indigent, pregnant noncitizen has reached the status of Medicaid recipient, in conclusion, that gives the person an invaluable protection—not just the EMTALA-based right to have the delivery performed and nothing else, but also access to a much broader array of contraceptive, prenatal, labor and delivery, and postpartum care options. Even those receiving Medicaid might be said to be reaping the benefits of advances in reproductive technologies, when their healthcare access is considered vis-à-vis that of indigent noncitizens. This realization reinforces the view that noncitizens are the least advantaged among us.

IV. Towards A Prioritarian Community: Reshaping the Terrain

The scant federal assurances and patchwork protections across the country for noncitizen reproductive rights are contrary to the spirit of cases like Griswold, Roe, and Casey, for these cases proclaim reproductive rights to be basic to personal liberty, privacy, and autonomy—“fundamental” as a matter of constitutional law, albeit not fundamental in the same sense of the non-derogable rights of international human rights law.

Further, our failure to protect noncitizen reproductive rights could have palpable, negative consequences on neonatal outcomes. Some surveys have found increased rates of


75 Id. at 4.

neural tube defects to infants born to immigrant women along the U.S.-Mexico border,\textsuperscript{77} for example, which can cause serious, lifelong health issues for the infants born—an outcome that could be greatly reduced in prevalence by promoting greater use of low-cost options like prenatal vitamins. Studies of noncitizen communities have also found that group to be less likely than the general population to access prenatal care during pregnancy.\textsuperscript{78} Thus, a reason for extending reproductive technologies to noncitizens is similar to the spirit and focus of DACA on children—it is a way of showing compassion to the future children of noncitizens, precisely by way of increasing the access of present noncitizens to reproductive tools. A failure to show this compassion via expanding noncitizen access to these technologies could have constitutive, lifelong, deleterious health and quality-of-life effects for the children born.

Beyond increasing access to indirect tools like government IDs, employment, and education, reforms could involve more expansive coverage under federal programs that affect the access of low-income undocumented individuals to nutrition options like prenatal vitamins. Currently, a person who is fully undocumented (one not falling into any of the qualified noncitizen categories) would be faced with the same problem under any federal programs for low-income individuals: in addition to Title X, programs like SNAP and WIC only extend to low-income citizens and low-income qualified noncitizens. Therefore, in a direction opposite to the recent actions of Attorney General Jeff Sessions to remove domestic and gang violence claims from the category of valid asylees, another way to improve noncitizen access to reproductive tools is to broaden the applicability of the qualified non-citizen category. There is good reason not to do away with the qualified category entirely, though, since there can be practical importance in ensuring noncitizens facing particularly imminent fears of death or persecution have some measure of priority over other noncitizens not facing imminent, palpable harms.

Securing noncitizen reproductive rights would be of paramount concern for a community that values ethical and political “prioritarianism.” The prioritarian view has become well known through a thought experiment posited by one of its earliest defenders, John Rawls.


\textsuperscript{78} Paul L. Geltman & Alan F. Meyers, \textit{Immigration Legal Status and Use of Public Programs and Prenatal Care}, 1 \textit{J. Immigrant Health} 91 (1999).
Rawls’s justification for prioritarianism rests on his starting point that theoretical deliberators behind a “veil of ignorance” would adopt it.\(^79\) The people in the veil of ignorance thought experiment are described as deliberating about which principles of justice to adopt for their society, with the veil of ignorance preventing each of them from knowing their actual class, gender, sex, race, health status, physical capabilities, and other idiosyncratic characteristics. Prioritarianism develops in this context as an agreement and an intuitive insurance protection: people behind the veil would agree to principles of justice that are to the greatest advantage of the least advantaged members of society as a precautionary risk protection, in case any of them finds that they are the least advantaged members of society once the veil is lifted.

A prioritarian community is not necessarily defined as one that helps the least advantaged members of society only because it is cost effective to do so. To be sure, utilitarians and welfare economists might often endorse prioritarian outcomes because of diminishing marginal utility: under a cost-benefit analysis, a dollar is worth more to the indigent than it is worth to the wealthy. While the overriding moral principle for utilitarianism is to maximize utility, Rawls draws on democratic values like liberty and equality. Prioritarian values also often undergird rationales for progressive taxation, imposing financial burdens on the comparatively well-off in order to fund social programs for the least advantaged.

With respect to the value of liberty, it should be noted that prioritarian reforms in expanding access to reproductive tools might be objected to particularly by libertarians. The libertarian argument might run as an objection to expanding government funding in general, or it might be an objection to expanding funding to reproductive tools, or to expanding funding to specific reproductive tools like abortion. Though the libertarian argument may seem significant, the broad contours of a reformed, alternative terrain of reproductive policy proposed by this article can account for it as an objection. A radical first step in creating this terrain of reproductive justice could be to place a moratorium on the broad holdings of the Supreme Court defining reproductive rights in *Griswold, Eisenstadt, Roe*, and *Casey*. The previous sections have shown the thorough disadvantage that noncitizens face within the realm of reproductive policy. Further, the historical roots of this disadvantage seem but a continuation of a long history from the xenophobia of the Gilded Age and Progressive eras,\(^79\) John Rawls, *A Theory of Justice* 118 (1971).
to the hereditarian pseudoscience and involuntary sterilizations of the eugenics period, to the Supreme Court’s decisions—most relevantly beginning in the 1970s—that protected and entrenched the reproductive interests of those who already held a comparative advantage in accessing reproductive tools. To some extent, these decisions could be justified under prioritarian principles because women in general could be described as the least advantaged vis-à-vis men in the context of labor and employment, with contraception and abortion, as mentioned, being components of helping to bring women de facto equality in the workplace.

At the same time, however, a counterfactual history might have witnessed the abortion right taking shape in a very different manner. It might have involved the Court choosing instead to grant writ to a Medicaid recipient seeking an abortion, rather than the native-born, middle-class, white plaintiff in Roe. Abortion could still have become legal in this counterfactual history, but instead of its on-demand form for those who can afford it, abortion could have been recognized as a right that requires public funding, for example, as a “medically necessary” public entitlement under the Medicaid statute. This would fit well with respecting the doctor-patient relationship, and it would still allow ample room for exceptions when appropriate.

In the actual world, by contrast, it was the on-demand, pay-to-play form of reproductive rights available to those with financial means that became constitutional law, while public funding to abortion has remained cut off by the Hyde Amendment, and with indigent, non-qualified noncitizens being unable to take advantage of programs like Title X, SNAP, and WIC. Given the history of reproductive policy in the U.S., it should be clear that fundamental reforms to the present terrain of reproductive policy are necessary to better reflect prioritarian values. A Supreme Court holding that eschewed the on-demand, pay-to-play type of abortion it had previously instituted, and put in its place a limited public entitlement to abortion, would be revolutionary indeed, but that aspiration is one possible step that could be taken towards shaping the field of “reproductive justice” more concretely around prioritarian values. Given the Court’s first pro-life holding in over a decade in the abortion context in NIFLA v. Becerra,\textsuperscript{80} as well as Justice Anthony Kennedy’s announced retirement under a Republican presidential administration and the anticipated shift of the Court to the political right, there is a real possibility that the terms of reproductive justice will

\textsuperscript{80} 585 U.S. ___ (2018).
soon be reconsidered.

Further, for the same reason that such a moratorium and redrafting of the terms could lay an initial foundation, a prioritarian distribution of reproduction-related resources should additionally have an outlook disfavoring expanding general access to reproductive tools for the purposes of human enhancement. This is not because of an independent objection to the possibility of “designer babies” through in vitro fertilization, preimplantation genetic diagnosis, and genetic manipulation. Nor is it because of an independent objection to expending public funds on making those reproductive tools more widely available. Rather, it is because the past century of reproductive policy has made indigent noncitizens the least advantaged members of society with respect to accessing reproductive tools. Instead of an objection to enhancement per se, the objection is rather that it would seem contrary to prioritarian principles to allocate any resources to enhancement—inasmuch as this involves improving the lives and progeny of those who are already comparatively well off—before a more concerted effort has been given to meeting the fundamental reproductive rights of the least advantaged first.

Prioritarianism, with respect to reproductive tools, should also be anti-enhancement in outlook because, as Michael Sandel has argued, reproductive technologies can and do entrench class stratification by facilitating the possibility that stratifications developing from financial differences will develop along biological lines as well.\(^1\) That is, permitting or encouraging genetic enhancement makes it easier for those with enough financial means to reinforce their privilege in subsequent generations, deepening the divide between them and those who cannot afford such reproductive tools. Only once rough equality is achieved with respect to the ability of all members of society to access reproductive tools and technologies (i.e., there would no longer be a “least-advantaged” group in this respect if equality were achieved) should we begin to probe into the value of lifting federal restrictions on enhancement towards the goal of making genetic enhancement technologies more accessible on demand to those with the ability to pay.

If not through redefining the terms at the level of Supreme Court reproductive policy, further reforms could move in the direction of measures like DACA, as increasing access to documentation, education, and employment opportunities can thereby indirectly promote

\(^1\) See generally Michael Sandel, The Case against Perfection (2007).
access to reproductive rights—whether documentation enabling access to abortion services at places like Planned Parenthood, employment opportunities including insurance coverage for contraceptives, or even sex education discussions in public schools. Expanding the definition of a qualified noncitizen can also be helpful towards this end, to facilitate greater noncitizen coverage under existing programs like Title X, SNAP, and WIC.

In conclusion, under the drastically different terrain of reproductive policy envisioned in these above reforms, the libertarian objection can largely be parried. The ideal solution I have proffered would indeed result in federal expansion on expenditures over reproductive tools: instead of being disbarred from expending any funds on abortion related services, as presently required under the Hyde Amendment, those services would instead become a public entitlement. However, the counterfactual terrain I have suggested could be still be justified for reasons rooted in morality and justice, for—whether rooted in the historical disadvantage that the indigent and noncitizens have faced in reproductive policy, or in the realities of the disadvantages they continue to face—prioritarian values support prioritizing this group’s needs as paramount, if reproductive justice is to be possible at all. Prioritarianism is a theory of distributive justice, and the reforms I have suggested apply this theoretical framework of distributive justice to the field of reproductive justice, suggesting reforms on the grounds of both distributive and reproductive justice.

These reforms of reproductive, distributive justice are also supported by moral reasons inasmuch as a libertarian or other objection is focused on abortion; reforms envision this right not as overall expanding in scope, but rather as becoming much more restricted for comparatively well-off people, and only expanding with respect to the least advantaged members of society—and even then only in cases of medical necessity. It is conceded that a libertarian objector may insist: “Regardless of the value of these reforms to infrastructure, I do not want my hard-earned money to be taxed to support abortion” (given that prioritarianism favors progressive taxation). In response to this objection, this article’s proposed reforms seek to stake out a compromising position—allowing there to be a federal abortion right rather than doing away with it altogether. Under this assumption that there will be a federal right to abortion, I instead place the right with a group in greater need of it. In tandem with limiting all abortions only to cases of medical necessity, this should diffuse

many of the background moral objections to abortion. If the objection persists even with those limitations, it seems more clearly to be an issue with abortion alone, rather than the underlying theory of distributive justice.

In any event, this objection is less likely to exist with other reproductive tools like contraception and prenatal care. There are also moral reasons to expand access to reproductive tools like sex education, contraception, prenatal vitamins, genetic counseling, and prenatal testing, screening, and care—namely, many of the precise reasons that reproductive tools have been described as “fundamental”: numerous courts across the country have interpreted federal reproductive policy to protect access to these tools as a fundamental right of personal autonomy, liberty, wellbeing, and freedom as a matter of U.S. constitutional law.

One of the reasons reproductive rights continue to be a hotly debated issue is because many people stopped agreeing with the Supreme Court’s substantive due process jurisprudence after it expanded that doctrine beyond the privacy of marriage and choices about how to raise one’s family so as also to include a categorical, on-demand, pay-to-play right to abortion that extends throughout the entirety of a pregnancy. The counterfactual terrain suggested here also can accommodate such moral objections to abortion being a constitutional right, inasmuch as the reforms are a disjunction rather than a continuation of that thread of the Court’s jurisprudence. Yet these reforms are a divergence that still uphold the value of women and men’s rights to reproductive choice—but do so by way of starting from scratch in defining the federal terms of reproductive choice, reproductive freedom, reproductive rights, and reproductive justice to ensure they are defined so that absolute priority is given to the needs of the least advantaged members of society. Towards that end, the history of reproductive policy in the U.S. has suggested an essential starting place would be to tend to the reproductive interests of indigent noncitizens.

This article has attempted to provide an aspiration of the type of community we could be. That community gives especial attention, gives priority, to the needs of the most marginal members of society—whether undocumented, LPR, dreamer, asylee, refugee, trafficking victim, or other victims of violence. Priorititarian reforms to the terrain of reproductive rights would tend to the needs of noncitizens because our country’s culture, society, and law has declared for nearly half a century that reproductive rights are fundamental rights that are central to one’s personal identity, development, and ability to live a free and autonomous
life. Those rights have become deeply engrained in contemporary society. Further, a choice not to tend to noncitizen reproductive rights is a failure with reverberating consequences, consequences that will imprint our values—such as how we treat the least advantaged among us—on future generations.

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