Georgetown Journal on Poverty Law and Policy
Volume XXXII, Number 2, Winter 2025

NOTES

Refusing to Get Used to the Pains: A Path Towards Affordable, Equitable, and Non-Coercive Care for Low-Income Women

Anna Kutbay*

ABSTRACT

Efforts to improve health in the United States frequently exclude one group in particular: low-income communities. Ironically, low-income people and families are often the ones who need improved care the most. Additionally, anti-poverty strategies neglect to consider the history of coercion and bias inherent in poor peoples' pursuit of healthy living and equitable care. This creates a devastating intersection specifically for low-income women who find that neither health policy nor anti-poverty policy has them in mind. This Note seeks to fill a gap in the literature by addressing this intersection. Additionally, topics like coercive birth control methods and predatory long-acting reversible contraceptives (LARC) practices are left out of larger conversations regarding birth control access due to the historic struggles to validate and decriminalize these options. This Note pushes the envelope by describing the drawbacks of these options while simultaneously offering solutions to improve them. Utilizing a timely approach to issues, like Medicaid and maternal health deserts, this Note also seeks to engage in rigorous anti-poverty scholarship while describing deficits and effects on women's care in the United States. This Note seeks to shed light on this vulnerable community by, in Part I, breaking down several areas of health insecurity for low-income women, then identifying potential remedies for these areas in Part II, and finally fleshing out tangible, effective solutions that could be implemented with the help of community organizers, lawmakers, and national organizations in Part III.

* J.D., Georgetown University Law Center, 2025; B.A. Economics and Political Science, M.A. Economics, The University of Alabama, 2022. I want to express my deepest appreciation to Professors Peter Edelman and Jessica Rosenbaum for their guidance in developing this piece in the 2023–2024 Poverty Law and Policy Practicum for which it was originally drafted, and to the Editors of the Georgetown Journal on Poverty Law & Policy for their hard work preparing this Note for publication.

Introduction

In an effort to learn more about barriers to health faced by low-income people, the Commonwealth Fund engaged in qualitative research that interviewed poor families and posted their anonymized responses in a collective.[1] Concerning the cost of care, one interviewee stated, "A consultation costs between $200 to $500. You don't have any money and you get very stressed if you have to pay for it. It is better to *get used to the pains you have*."[2] This idea of getting "used to the pains," whether they manifest in a physical sense or in an emotional, monetary, or psychological sense, is all too common for low-income individuals who do not have access to affordable care. Low-income women in particular find themselves in an incredibly vulnerable position; women generally need more healthcare than men do, and are simultaneously more likely to be poorer than men.[3] Identifying what exactly within the healthcare system leaves poor women in particular so vulnerable is a crucial step toward solving those problems. This Note seeks to do that. By diving deep into three specific areas that women are harmed in reproductive or gender-based care, solutions that focus on women and their families can be created that ensure women are actually able to live without the pains, instead of merely getting used to them.

A few necessary clarifications are in order. First, this paper recognizes and agrees that healthcare in the United States, generally and holistically, is flawed

1. Corinne Lewis, Melinda K. Abrams & Shanoor Seervai, *Listening to Low-Income Patients: Obstacles to the Care We Need, When We Need It*, Commonwealth Fund (Dec. 1, 2017), https://www.commonwealthfund.org/blog/2017/listening-low-income-patients-obstacles-care-we-need-when-we-need-it.

2. *Id.* (emphasis added).

3. Gretchen Borchelt, *The Impact Poverty Has on Women's Health*, 43 ABA Hum. Rights 70, 70 (2018).

for those living below *and* above the poverty line. As is a common refrain, the United States is a health *insurance* country, not a health *care* country.[4] Within this flawed system is the ignorance about low-income women's struggles to survive; this Note focuses specifically on them. Next, this Note does not seek to argue for radical or untenable changes. For example, while this paper will later argue that the Hyde Amendment needs to be repealed, and that coalition building around funding abortions needs to be more widespread, this paper will *not* argue that a liberal Supreme Court should take up a new abortion case or that we should throw all resources towards making abortion a federal right. While both of these steps could unquestionably help poor women, they overshadow deeper issues of accessing *current and available care* due to affordability, and these steps may be rather unachievable, blocking out useful, smaller-scale solutions in the process. Finally, this Note recognizes the nuances of gender–that those needing reproductive care or maternal healthcare may not always identify as a "woman." This Note uses the words "woman" and "women" to encapsulate those who need access to any of the health services or treatments discussed within the scope of the argument. Understanding the additional complexities that poor transmen, transwomen, and nonbinary people face when accessing their care is crucial, and additional scholarship must undertake these issues specifically to give them the nuanced perspective and attention they deserve.[5]

The Note proceeds as follows. Part I identifies each of the aforementioned problem areas that create challenges regarding access to and payment for reproductive and gender-based care: LARCs and other coercive practices, maternal health deserts, and Medicaid. Part II analyzes the problems laid out and discusses what potential solutions might look like. Part III builds on Part II by articulating the necessary structures, coalitions, funding schemes, and legislative goals that would achieve the outlined solutions.

I. Health-Harming Mechanisms in Place

While poverty can have an extremely detrimental impact on those trying to receive *any* type of healthcare, poverty makes accessing reproductive and gender-

4. *See* Mary Gerisch, *Health Care as a Human Right*, 43 ABA Hum. Rights 56, 57 (2018); *see also* Aaron E. Carroll, *I Studied Five Countries' Health Care Systems. We Need to Get More Creative with Ours*, N.Y. Times (June 13, 2023), https://www.nytimes.com/2023/06/13/opinion/health-care-reform.html.

5. Important framing and useful reading materials for this Note and others regarding the inclusion of transgender, nonbinary, and gender nonconforming individuals in conversations regarding gender-based care (especially from a poverty framework) are critical. Without this context and nuance, exposing inequities and achieving comprehensive, accessible care for all from an access *and* affordability standpoint is futile. *See, e.g.*, Heidi Moseson et al., *The Imperative for Transgender and Gender Nonbinary Inclusion*, 135 Beyond Women's Health 1059 (2020); Committee on Gynecologic Practice and Committee on Health Care for Underserved Women, *Health Care for Transgender and Gender Diverse Individuals*, 137 Am. Coll. Obstetrics & Gynecologists 75 (2017); Emma Carpenter, *"The Health System Just Wasn't Built for Us:" Queer Cisgender Women and Gender Expansive Individuals' Strategies for Navigating Reproductive Healthcare*, 31 Women's Health Issues 478 (2021).

based care in particular significantly more challenging. This is due to a combination of both unintentional barriers (not being able to take off work for an appointment or not having the funds necessary to receive care) and intentional barriers (Medicaid restrictions and curbed funding of abortion procedures). There are three significant barriers chosen in this Note that impact healthcare access and access to gender-based or reproductive care for women in poverty: the prevalence and predatory nature of long-acting reversible contraceptives (LARCs) and coercive practices, maternal health deserts, and Medicaid terminations and exclusions. These three barriers each have their own concrete solutions, but there are also intersecting, overarching solutions to address these problems that low-income women face.[6] All solutions focus on reproductive justice, restoration of access, regulatory oversight, legislative action, and community organizing.

A. LARCs and Coercive Birth Control Practices

Long-acting reversible contraceptives are implanted devices that are effective at preventing pregnancy for a significantly longer time than other birth control methods, taking the form of intrauterine devices or subdermal arm implants.[7] These methods can prevent pregnancy for as long as ten years.[8] The efficacy of LARCs is well-known; the problem actually lies in this very fact. LARCs must be carefully prescribed, the language around LARCs must change, and access must be balanced with the prevention of coercion. This section will argue against the use of LARCs as the ultimate poverty cure, discussing the problems of coercion in prescriptions for LARCs and other forms of birth control, and its historical roots.

LARCs' popularity grew out of the idea that long-acting, low-maintenance birth control would enable women to escape poverty and enjoy stability.[9] Instead of less convenient and less effective methods, like the birth control pill, LARCs can temporarily sterilize a woman without daily action and therefore better prevent unexpected pregnancy. However, the effectiveness of LARCs that initially made them so desirable also carries with it a sinister backdrop of coercion. Additionally, those in the medical field have debated whether or not LARCs

6. *See infra* Part III.

7. *See* Elizabeth L. Stark, Aileen M. Gariepy & Moeun Son, *What is Long-Acting Reversible Contraception?*, 328 JAMA 1362, 1362 (2022); *Long-Acting Reversible Contraception (LARC): Intrauterine Device (IUD) and Implant*, AM. COLL. OBSTETRICS & GYNECOLOGISTS (Apr. 2024), https://www.acog.org/womens-health/faqs/long-acting-reversible-contraception-iud-and-implant.

8. *Long-Acting Reversible Contraceptives (LARCs)*, PLANNED PARENTHOOD, https://www.plannedparenthood.org/planned-parenthood-columbia-willamette/patient-resources/long-acting-reversible-contraceptives-larcs (last visited Feb. 26, 2024).

9. *See, e.g.*, Christine Dehlendorf & Kelsey Holt, *The Dangerous Rise of the IUD as Poverty Cure*, N.Y. TIMES (Jan. 2, 2019), https://www.nytimes.com/2019/01/02/opinion/iud-implants-contraception-poverty.html (juxtaposing researchers' ideas that IUDs can curb poverty rates with the historical backdrop of coercive sterilization practices against low-income people).

actually deliver on their promise to curb poverty, weakening LARC proponents' argument for their widespread, unadulterated use.[10]

LARC use has often been tied to racist, ableist, and discriminatory practices targeting low-income communities and communities of color.[11] Starting during the Jim Crow era, sterilization and reproductive constraint were seen as anti-poverty solutions primarily for Black women.[12] States like North Carolina sterilized thousands of women for being Black and poor, disguising reproductive science as a supposed poverty cure.[13] The fall of surgical sterilization as a practice—due in large part to voices condemning the practice, rightfully, as eugenics[14]—coincided with the rise of LARCs. For example, when the LARC Norplant was first introduced and subsidized by Medicaid, proponents argued that those on welfare and eligible for Medicaid should be *required* to receive the implant in order to continue receiving benefits.[15] Even today, some doctors utilize pre-prescription counseling as a way to "sell" LARCs as the optimal method of birth control for patients due to its efficacy, instead of using a patient-centered approach that takes into consideration the wants, needs, and health of the individual.[16] The power dynamics inherent in the doctor's office make these conversations coercive: poor patients see LARCs as the only option for their birth control needs and may feel pressured to use them lest they be seen as a difficult patient.

LARCs do not encapsulate the full range of coercive reproductive tactics targeting low-income communities. For example, states have offered sterilization as a means for individuals to reduce their sentences of incarceration or increase their

---

10. *Compare* Diana G. Foster, *The Problems With a Poverty Argument For Long-Acting Reversible Contraceptive Promotion*, 222 Am. J. Obstetrics & Gynecology 861, 861–63 (2020) (arguing that LARC use will *not* tangibly reduce national poverty levels), *with* Jason M. Lindo, *Weighing the Evidence On the Likely Effects of Expanding Access to LARCs on Poverty*, 222 Am. J. Obstetrics & Gynecology 864, 864–65 (2020) (arguing that LARCs *do* prevent poverty by reducing unintended pregnancies).

11. *See* Olivia Cappello, *Powerful Contraception, Complicated Programs: Preventing Coercive Promotion of Long-Acting Reversible Contraceptives*, 24 Guttmacher Pol'y Rev. 36, 36 (2021), https://www.guttmacher.org/sites/default/files/article_files/gpr2403621.pdf. *See generally* Dorothy Roberts, Killing the Black Body: Race, Reproduction, and the Meaning of Liberty (2d ed. 2017) (chronicling historic and modern racist practices towards Black women that denied them reproductive autonomy while serving the interests of white supremacists, including the rise in coercive prescribing of LARCs like Norplant).

12. Roberts, *supra* note 11, at 3.

13. *See* Alexandra Minna Stern, *Forced Sterilization Policies in the US Targeted Minorities and Those with Disabilities—and Lasted Into the 21st Century*, Conversation (Aug. 26, 2020, 8:20 AM), https://theconversation.com/forced-sterilization-policies-in-the-us-targeted-minorities-and-those-with-disabilities-and-lasted-into-the-21st-century-143144.

14. Roberts, *supra* note 11, at 65, 72, 97–98.

15. *See* Stern, *supra* note 13; Roberts, *supra* note 11, at 4–5, 104, 108–09; *see also* Jamila Taylor, *The Promotion of Long-Acting Contraceptives Must Confront History and Center Patient Autonomy*, Rewire News Grp. (Aug. 15, 2016, 6:14 PM), https://rewirenewsgroup.com/2016/08/15/larcs-history-autonomy/.

16. *See* Cappello, *supra* note 11, at 39; Roberts, *supra* note 11, at 136.

public benefits.[17] This practice monetizes a person's reproductive choices by allowing them to trade in their reproductive capabilities for basic necessities. Providing this "choice" preys on those who may have no other option than to become sterilized to avoid jail, obtain increased funds for their family, or feel more accepted as an "ideal" poor person according to societal standards. Especially now, birth control is a heavily debated issue between conservatives and liberals; but conversative voices seemed, at one point or another, to agree on the widespread use of birth control in the anti-poverty context, as seen with conditioning poor women's welfare receipt on the use of Norplant.[18]

Further, the reality of LARCs' ties to curbing poverty may not be as clear as frequently articulated. Proponents of pushing long-acting birth control on poor women insist that it could be used as a poverty cure. However, applying a more critical lens to this argument reveals its flawed assumptions. This Note does not seek to make the argument that birth control plays *no* role in helping women escape poverty or obtain necessary healthcare, which is patently untrue. What it does seek to clarify is that LARCs cannot be deemed an overarching, absolute method of poverty reduction.

Promoting birth control as a poverty cure ignores larger structural problems—such as a failing safety net and a dearth of jobs paying a living wage—that will still persist even if these campaigns are successful.[19] This effectively means that even if birth control were embraced as a way to reduce poverty, other overarching problems demonstrate that it is not an end-all solution. Anti-poverty policy goals focused on *other* areas, like improving education, increasing entitlement programs and benefits, expanding programs like the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), establishing a universal basic income (UBI), or implementing universal childcare would likely have significantly better, longer-lasting results that would reduce poverty without intruding on matters of reproduction. Take, for example, the COVID-era child tax credit, which cut childhood poverty in

17. *See, e.g.*, *Inmates Offered Reduced Sentences for Birth Control Procedure*, BBC (July 21, 2017), https://www.bbc.com/news/world-us-canada-40677725 (describing a Tennessee judge who offered sentence reductions if incarcerated men received vasectomies and women received LARCs); Tamar Lewin, *A Plan to Pay Welfare Mothers for Birth Control*, N.Y. TIMES (Feb. 9, 1991), https://www.nytimes.com/1991/02/09/us/a-plan-to-pay-welfare-mothers-for-birth-control.html (describing one of the first bills, proposed in Kansas, that would reimburse women on welfare $500 if they received a Norplant implant).

18. For example, Republicans in states like Kansas, Tennessee, and Louisiana, and Democrats in states like Connecticut and California all immediately proposed extra benefit allocations and yearly financial bonuses for poor women who received Norplant and kept it inserted. ROBERTS, *supra* note 11, at 108–09.

19. *See, e.g.*, Alexandra Cawthorne Gaines et al., *How Weak Safety Net Policies Exacerbate Regional and Racial Inequality*, CTR. AM. PROGRESS (Sept. 22, 2021), https://www.americanprogress.org/article/weak-safety-net-policies-exacerbate-regional-racial-inequality/ (finding that "[R]egions with weaker safety nets have higher rates of hardship and worse economic outcomes overall"); DAYFORCE, 2024 DAYFORCE LIVING WAGE INDEX 3–4, https://www.dayforce.com/Ceridian/media/documents/2024-Living-Wage-Index-FINAL-1.pdf (highlighting that "44% of full-time workers do not earn enough to cover their family's basic needs").

half but was not reinstated, leading to a later increase in childhood poverty exceeding pre-COVID levels.[20] Instead of idealizing birth control as a poverty cure, solutions that have proven to work to reduce family poverty should be expanded, reinstated, and prioritized. Anti-poverty goals need to be rooted *elsewhere* than reproduction to actually be sustainable and ethical; controlling who deserves to have children is a sinister, outdated solution to a problem that could be solved, instead, by investing in communities.[21]

B. Maternal Health Deserts

Maternal health deserts are areas within the United States without adequate access to hospitals offering obstetric care, birthing centers, or certified nurses and midwives.[22] While access levels vary between maternal health deserts, low access is defined as having "one or less hospital offering OB service and fewer than sixty OB providers per 10,000 births," and areas where "the proportion of women without health insurance was 10% or greater."[23] Over one third of counties in the United States qualify as being maternal health deserts, resulting in over two million women living in these areas with scarce care. A majority of counties qualifying as maternal health deserts are in the Midwest and South.[24] This coincides not only with areas experiencing the largest rates of poverty but also with predominantly Black communities; one in six Black babies are born in maternal health deserts.[25] Maternal health deserts are created by the closure of facilities offering OBGYN services and procedures. The cause of these closures lies in a number of factors, including the fact that these areas have higher proportions of Medicaid recipients.[26] Medicaid pays significantly less than private insurance, which means

---

20. *See* Sophie Collyer, Bradley Hardy & Christopher Wimer, *The Antipoverty Effects of The Expanded Child Tax Credit Across States: Where Were the Historic Reductions Felt?*, BROOKINGS INST. (Mar. 1, 2023), https://www.brookings.edu/articles/the-antipoverty-effects-of-the-expanded-child-tax-credit-across-states-where-were-the-historic-reductions-felt/; Sharon Parrott, *Record Rise in Poverty Highlights Importance of Child Tax Credit; Health Coverage Marks a High Point Before Pandemic Safeguards Ended*, CTR. FOR BUDGET & POL'Y PRIORITIES (Sept. 12, 2023), https://www.cbpp.org/press/statements/record-rise-in-poverty-highlights-importance-of-child-tax-credit-health-coverage.

21. For more on this idea, see ROBERTS, *supra* note 11, at 108–09. Roberts' book dives into the idea that relying on curbing reproductive capabilities for *any* policy goal (poverty reduction included) is coercive and ignores the well-being of poor women. It is based on eugenicist ideas of reducing "unfit" populations – i.e., in the eyes of some policymakers, poor Black families.

22. *See Maternity Care Desert*, MARCH OF DIMES (last updated Dec. 2023), https://www.marchofdimes.org/peristats/data?top=23&lev=1&slev=0.

23. *Nowhere to Go: Maternity Care Deserts Across the U.S. (2022 Report)*, MARCH OF DIMES https://www.marchofdimes.org/sites/default/files/2022-10/2022_Maternity_Care_Report.pdf [hereinafter *March of Dimes Report*].

24. Rachel Treisman, *Millions of Americans Are Losing Access to Maternal Care. Here's What Can Be Done*, NPR (Oct. 12, 2022, 9:37 A.M.), https://www.npr.org/2022/10/12/1128335563/maternity-care-deserts-march-of-dimes-report; Erika Edwards, *Pregnant Women are Less and Less Able to Access Maternity Care*, NBC NEWS (Sept. 10, 2024, 9:00 AM), https://www.nbcnews.com/health/health-news/pregnant-women-cant-find-doctors-growing-maternity-care-deserts-rcna169609.

25. Treisman, *supra* note 24.

26. *See* Andrea Sonenberg & Diana J. Mason, *Maternity Care Deserts in the US*, 4 JAMA HEALTH F., Jan. 2023, at 1, 2.

that facilities in these areas receive less income than their counterparts, often leading to their closure.[27]

Maternal health deserts are concerning for a number of reasons. Women living and giving birth in maternal health deserts are 91% more likely to die during childbirth or experience postpartum complications than those living outside of these zones.[28] Women in care deserts lack the necessary support and services to ensure healthy and successful pregnancies. Due to the limited number of facilities, these women have a decreased ability to go to checkups, get advice on their health, and quickly receive emergency care. All of this leaves low-income women in maternal care deserts extremely vulnerable and unable to access reproductive care.

The lack of doctors and the closing of facilities is incredibly detrimental for poor women seeking basic check-ups. For example, Planned Parenthood clinics offer a variety of services beyond abortion: birth control, STI and HIV screenings, and well visit check-ups.[29] But recently, many locations have shuttered due to financial struggles and changes in reproductive health policies.[30] Their closures or reduced offerings of care means a loss of these services for all. Given that Planned Parenthood strives to make care accessible, this is especially devastating for poor women seeking basic health services.

Deserts of care are calamitous for low-income women. Without access to extremely vital care, many women, pregnant or not, are left in vulnerable positions where they cannot get their health assessed. And even if they were physically able to, the costs of doing so would make the care unattainable; having to take off work, pay for childcare, gas or public transportation to a far-off clinic, and possibly stay overnight, among a slew of other costs, would likely lead many to answer the question of whether or not to receive care in the negative.

C. Medicaid Termination and Exclusions

Medicaid covers over eighty-two million individuals in the United States, providing essential care for those who need it.[31] All states participating in Medicaid cover LARC methods through family planning services and Title X.[32]

---

27. *See id*.

28. Maeve Wallace et al., *Maternity Care Deserts and Pregnancy-Associated Mortality in Louisiana*, 31 WOMEN'S HEALTH ISSUES 122, 124 (2021).

29. *Health Center Expansions and Closures*, PLANNED PARENTHOOD, https://www.plannedparenthood.org/planned-parenthood-northern-new-england/campaigns/expansions-and-closures (last accessed Sept. 22, 2024).

30. *See, e.g.*, Spencer Conlin, *Planned Parenthood of Greater New York Seeks to Close 3 Clinics*, SPECTRUM NEWS 1 (Aug. 8, 2024, 6:25 PM) (explaining that some clinics cite "financial and political hurdles" and "reimbursement rates that lag behind" other centers as reasons for forced closures).

31. *Medicaid State Fact Sheets*, KFF (Aug. 14, 2024), https://www.kff.org/interactive/medicaid-state-fact-sheets/.

32. Jenna Walls et al., *Medicaid Coverage of Family Planning Benefits: Results from a State Survey*, KFF (Sept. 15, 2016), https://www.kff.org/report-section/medicaid-coverage-of-family-planning-benefits-results-from-a-state-survey-reversible-contraception/.

This includes LARC removal.[33] As previously mentioned, Medicaid also funds maternal health services.[34] Medicaid is an incredible program that enables women to receive necessary general and gender-based care. However, two problems affect Medicaid's ability to actually ensure access to care for low-income women: terminations and exclusions. As used here, termination involves individuals losing their medical insurance; exclusion refers to services that are excluded despite being important.

First, Medicaid terminations can pose serious problems for women with health needs. States that have not adopted the Medicaid expansion have been experiencing a "coverage gap" since the Supreme Court's ruling in *National Federation of Independent Business v. Sebelius* held that expanding Medicaid was *optional*.[35] This created a gap where those who would have been covered by Medicaid now find themselves without care. Medicaid eligibility in many of these states falls at around 38% of the federal poverty line, and marketplace insurance is usually only available to those with incomes over 100% of the federal poverty line; therefore, individuals within the 38% to 100% range are neither covered by Medicaid nor eligible for marketplace insurance, meaning they fall into a "gap."[36] This essentially means that despite being categorically poor, these families are not "poor enough" to receive Medicaid. Those who had previously qualified for Medicaid due to the Affordable Care Act expansion nullified by *Sebelius* are now uninsured; states not expanding coverage, even with President Biden's financial incentive to close the gap, leaves individuals vulnerable.[37] This coverage gap includes over 1.5 million people.[38] Additionally, post-COVID, many states are reevaluating their Medicaid eligibility; this has resulted in coverage terminations for millions more.[39] Medicaid terminations in coverage pose unique risks

---

33. Cappello, *supra* note 11, at 37.

34. Sara Rosenbaum et al., *The Road to Maternal Health Runs Through Medicaid Managed Care*, COMMONWEALTH FUND (May 22, 2023), https://www.commonwealthfund.org/blog/2023/road-maternal-health-runs-through-medicaid-managed-care.

35. 567 U.S. 519 (2012); *see* JUDITH SOLOMON, CTR. ON BUDGET & POL'Y PRIORITIES, FEDERAL ACTION NEEDED TO CLOSE MEDICAID "COVERAGE GAP," EXTEND COVERAGE TO 2.2 MILLION PEOPLE 1 (May 6, 2021), https://www.cbpp.org/sites/default/files/5-6-21health.pdf.

36. Robin Rudowitz et al., *How Many Uninsured Are in the Coverage Gap and How Many Could be Eligible if All States Adopted the Medicaid Expansion?*, KFF (Feb. 26, 2024), https://www.kff.org/medicaid/issue-brief/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/("Adults who fall into the coverage gap have incomes above their state's eligibility for Medicaid but below poverty, making them ineligible for subsidies in the ACA Marketplaces . . . When enacted, the ACA did not anticipate that states would be permitted to forgo Medicaid expansion; as such, subsidies in the Marketplaces are not available for people with incomes below poverty."); *see also id.* at Fig. 2 (highlighting that individuals falling between 38% and 100% of the federal poverty line fall into this coverage gap for having incomes that are simultaneously too high *and* too low).

37. SOLOMON, *supra* note 35, at 1.

38. *Id*.

39. Akeiisa Coleman, *Almost 3.8 Million People Have Lost Their Medicaid Coverage Since the End of the COVID-19 Public Health Emergency*, COMMONWEALTH FUND (Aug. 9, 2023), https://www.commonwealthfund.org/blog/2023/almost-38-million-people-have-lost-their-medicaid-coverage-end-covid-19-public-health. *But see Medicaid Enrollment and Unwinding Tracker*, KFF (Sept. 12, 2024) ("As of

for women in particular. For example, women who choose to get a LARC while on Medicaid could risk losing their Medicaid benefits if they fall into the coverage gap; if they cannot afford care without Medicaid, they may have difficulty getting their LARC removed. This essentially means that without healthcare, a woman loses her reproductive autonomy. Without uninterrupted and guaranteed care, women may find themselves struggling to attain their health needs. This again means that women will forgo care due to expense or inaccessibility of affordable care.

Second, exclusions harm predominantly poor women. For example, the Hyde Amendment curbed the ability of Medicaid to pay for abortions, excluding coverage for women seeking them.[40] This Amendment, passed in 1993, forbids federal funds to be used to pay for abortions outside of a few exceptions.[41] States can use their own funds to subsidize abortion care under state Medicaid programs,[42] but only sixteen states actually do.[43] Almost all states that do not fund abortions are states with the highest rates of poverty, demonstrating that women in poverty are the ones with the most restricted access to this type of care.[44]

The average cost of an abortion is almost $500.[45] This is just the cost of the procedure–many women also have to pay various costs associated with travelling

---

September 12, 2024, at least 25,198,000 Medicaid enrollees had been disenrolled during the unwinding of the continuous enrollment provision."). At the time of editing this Note, the number of individuals who have been disenrolled has increased, varying by state. *Id.* Additionally, KFF details that 69% of those disenrolled were terminated for "procedural reasons." *Id.* As they accurately state, though, "High procedural disenrollment rates are concerning because many people who are disenrolled for these paperwork reasons may still be eligible for Medicaid coverage." *Id.* It is absolutely not unlikely that many procedurally disenrolled individuals are poor, and thus may actually be "poor enough" to receive state Medicaid, but were disenrolled for other reasons.

40. Medicaid is funded by both states and the federal government. The Hyde Amendment prohibits specifically *federal* funds from being used to cover abortion services. Therefore, in thirty-four states and D.C., the Hyde Amendment severely constricts funding for abortion (the other sixteen states provide their own funding). *The Hyde Amendment: A Discriminatory Ban on Insurance Coverage of Abortion*, GUTTMACHER INST. (May 2021), https://www.guttmacher.org/fact-sheet/hyde-amendment.

41. Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1994, Pub. L. No. 103-112, § 509, 107 Stat. 1082, 1113 (1993) (prior to 2013 Codification Act). Exceptions include rape, incest, and "to save the life of the mother." *Id.* A very interesting, noticeable fact about the Amendment is that the abortion preclusion is the second to last paragraph/section, seated only before the paragraph clarifying what the Act is to be called. *Id.* Adding this extremely restrictive section to the very bottom of the bill (also called a legislative "rider"), to me, very clearly establishes the intentionality of the bill authors.

42. Alina Salganicoff, Laurie Soble & Amrutha Ramaswamy, *The Hyde Amendment and Coverage for Abortion Services*, KFF (Mar. 5, 2021), https://www.kff.org/report-section/the-hyde-amendment-and-coverage-for-abortion-services-issue-brief-2/.

43. *Id*.

44. *Id*. An interesting exception is New Mexico, which does use state funds to cover abortion, yet is among the top ten states with the highest poverty rates. *See also* Heather D. Boonstra, *Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters*, 19 GUTTMACHER POL'Y REV. 46, 47 (2016), https://www.guttmacher.org/gpr/2016/07/abortion-lives-women-struggling-financially-why-insurance-coverage-matters ("In 2014, 49% of abortion patients had a family income below the federal poverty level . . .").

45. Boonstra, *supra* note 44, at 47.

to a doctor, missing work, finding childcare, and potentially staying overnight in a state with mandatory waiting periods.[46] For some women, these costs can total one-third of their monthly income.[47] Additionally, many low-income women cannot come up with the money necessary to have the procedure; a 2022 Federal Reserve study found that around 37% of adults, when faced with a $400 emergency expense, would either have to borrow the money, sell something they owned, or not pay it all.[48] Applying this statistic to abortion care, the choices that women have to make become vividly clear: find enough money to make it happen or forgo the procedure.

II. Analyzing Potential Solutions

Part II seeks to analyze the aforementioned problems and identify potential solutions. Each section connects a problem or concern faced by low-income women with ideas for solutions, setting the stage for both individualized and overarching solutions to each health-related issue. While Part III will actually lay out tangible solutions, Part II conceptualizes the problems and solutions that Part III works to solidify.

While these issues have individual solutions that can be implemented, there are several overarching solutions to address low-income women's access to reproductive healthcare. Poor women are not taken seriously when it comes to reproductive decision-making. This is due in large part to the false narrative that low-income women are incapable of making competent choices about their reproductive health.[49] Combating these negative stereotypes and implications will require current public interest groups and coalitions to come together. Currently, groups that could enact mass change and implement solutions surrounding low-income women's reproductive health are isolated, each focusing on their own issues without intersectionality. For example, organizations like March of Dimes, Planned Parenthood, Center for Law and Social Policy (CLASP), the Center on

---

46. *See Mandatory Waiting Periods for Women Seeking Abortions*, KFF, https://www.kff.org/womens-health-policy/state-indicator/mandatory-waiting-periods/(describing an abortion waiting period as a length of time between initial counseling and the abortion procedure) (last updated Aug. 30, 2023). Waiting periods have been justified as allowing for periods of so-called reflection before an individual gets an abortion. *See* Sam Rowlands & Kevin Thomas, *Mandatory Waiting Periods Before Abortion and Sterilization: Theory and Practice*, 12 Int'l J. Women's Health 577, 577 (2020). In reality, these waiting periods have been condemned by the World Health Organization; they contribute to higher workloads in clinics and doctor's offices, increase operation costs, and ultimately impede access to care. Fiona de Londras et al., *The Impact of Mandatory Waiting Periods on Abortion-Related Outcomes: A Synthesis of Legal and Health Evidence*, BMC Pub. Health, 2022, at 1, 1, 3, 7, 11.

47. Sarah Roberts et al., *Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States*, 24 Women's Health Issues 211 (2014).

48. *Report on the Economic Well-Being of U.S. Households in 2022 - May 2023 – Expenses*, Fed. Rsrv. Syst. (June 2, 2023), https://www.federalreserve.gov/publications/2023-economic-well-being-of-us-households-in-2022-expenses.htm.

49. *See, e.g.*, Roberts, *supra* note 11, at 106 (describing how, days after FDA approval of Norplant, many proposed that the birth control method would be a "solution to inner-city poverty" because, in their disturbing view, "people having the most children are the ones least capable of supporting them").

Budget and Policy Priorities, and others focus on issues that, in some way, deal with the aforementioned problems plaguing low-income women, but without enough coordination. Establishing a robust partnership or working group of representatives from each organization could combine resources to engage in a unified fight to ensure that low-income women have the resources they need and the policies to support them. Coalitions like these could help to implement the following more specific solutions to address each concern low-income women face.

A. Addressing Coercive Birth Control Practices

For those at the mercy of fluctuations in health insurance, poverty, and state surveillance of reproduction, LARCs sometimes do not provide an actual choice over one's reproductive health; the illusory choice inherent within them demonstrates embedded coercion and a history of racism and discrimination. LARCs must be monitored via federal oversight, fees and practices must be equalized among states, and coalition building must be implemented to ensure that low-income women are not stripped of reproductive freedom just for being poor.

First, LARC prescription and advertisement must be closely monitored to prevent coercion. Clear language in policy must be implemented to ensure that LARCs or other similar procedures are not pre-conditions for receipt of welfare for any individuals. Regulatory agencies like the FDA could implement this language; also, provider education and understanding of issues plaguing reproductive health could help restore patient autonomy.

Next, equalizing fees and practices for all contraceptive services would allow for more choice. A survey by KFF assessed states' coverage of certain family planning services.[50] Some states only supply limited quantities of short-term contraception at a time, and several do not cover emergency contraception.[51] A minority of states allow for pharmacists to prescribe contraceptives instead of a physician, which allows those without ready access to a doctor (because they live in a health desert, or because their socioeconomic status makes getting to a doctor difficult) to still access contraceptives.[52] Ensuring equal access—where states offering the least are required to bridge the gap and offer the same services as high-access states—is imperative to ensuring that all women receive the care they want and need.

Finally, coalition building on this issue is critical. The long history of LARC coercion is difficult for organizations to grapple with. Identifying problems with specific methods of birth control, especially when these methods have done an immense amount of good for all communities of women from a scientific and family planning perspective, seems like a step in the wrong direction. This is

50. Usha Ranji et al., KFF, Medicaid Coverage of Family Planning Benefits: Findings from a 2021 State Survey 34–39 (2022), https://www.kff.org/report-section/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey-report/.

51. *Id*. at 12–16, 34–39.

52. *Id*. at 19.

especially the case when many individuals and organizations have already fought to demystify, decriminalize, and make commonplace birth control for American women.[53] However, these organizations must start speaking out and influencing policy on the issue of LARC misuse alongside historic and modern coercive sterilization practices. If more interest groups begin vocalizing the existing problems, it can encourage the adoption of policy choices that safeguard authentic choice, help low-income women better know their rights, and likely create more victories for these groups.

B. Maternal Health Infrastructure Building

Neither states nor the federal government have adequate or intentional infrastructure intended to preserve maternal care facilities that rely on Medicaid or other forms of funding. Changing this would involve intentional funding in rural areas to support hospitals. Part of this investment should go directly to doulas and midwives. A doula is a trained specialist who provides support during the birthing process.[54] Doulas have been instrumental in decreasing the need for medical intervention during birth and reducing risks associated with pregnancy and childbirth.[55] This is because doulas provide prenatal support to promote healthy practices, develop birth plans for clients, and reduce stress during birth, all of which contributes to decreasing emergencies and absolving the health-harming impacts one could experience before and during birth.[56] Additionally, doulas have had a specific positive impact on the birthing experiences of women of color.[57] Racial

53. Thinking back to cases like *Griswold v. Connecticut* and *Eisenstadt v. Baird* reminds: cases fueled by public interest organizations directly (Planned Parenthood in *Griswold*) or public interests generally (Boston University students and William Baird in *Eisenstadt*) established this right to contraceptives that was both historic and revolutionary. Griswold v. Connecticut, 381 U.S. 479 (1965); Eisenstadt v. Baird, 405 U.S. 438 (1972); *see also Griswold v. Connecticut*, PLANNED PARENTHOOD OF WESTERN PA., https://www.plannedparenthood.org/planned-parenthood-western-pennsylvania/stay-informed/griswold-v-connecticut (last visited Sept. 22, 2024); *The 1972 Supreme Court Case Legalizing Contraception for All*, NAT'L FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOC., https://www.nationalfamilyplanning.org/pages/issues/eisenstadtvbairdmain (last visited Sept. 22, 2024). The same importance, significance, and fervor driving these cases and surrounding questions of access should also be given to the current issues of coercion faced by so many. Instead of treating the issue as untouchable or one that could potentially undo the work of the two aforementioned cases, the issue of coercive practices should be treated as yet *another* step forward for reproductive justice advocates and anti-poverty organizers. Access and anti-coercive safeguards go hand in hand—you cannot truly have one, meaningfully, without the other. *See* ROBERTS, *supra* note 11, at 136 ("[A] woman's freedom to *choose* among reproductive options does not mean she has reproductive *freedom*.") (emphasis added).

54. *See* Alexis Robles-Fradet & Mara Greenwald, *Doula Care Improves Health Outcomes, Reduces Racial Disparities and Cuts Cost*, NAT'L HEALTH LAW PROGRAM (Aug. 8, 2022), https://healthlaw.org/doula-care-improves-health-outcomes-reduces-racial-disparities-and-cuts-cost/.

55. *See id*.

56. *See id. See generally* Alexandria Sobczak et al., *The Effect of Doulas on Maternal and Birth Outcomes: A Scoping Review*, CUREUS, May 24, 2023, at 1.

57. *See* Robles-Fradet & Greenwald, *supra* note 54 ("Community-based doulas are particularly well suited to improve racial disparities in health outcomes by ensuring that pregnant people who face the greatest risk of discrimination and mistreatment in the medical system receive the additional support they require.").

discrimination in healthcare exposes women of color to "unfair treatment, harsh language, and rough handling during their hospital stay, as compared to white women."[58] Doulas become advocates, listeners, caregivers, and supporters for women of color who are frequently neglected by traditional health systems.[59] Five states currently reimburse individuals for doula services through Medicaid; an additional twenty-seven states have proposed legislation that would provide these services or reimburse them.[60] Ensuring that more states cover these types of services would bridge gaps left by maternal health deserts by ensuring that those struggling to find care can turn to doulas in times of need.

A core reason for maternal health deserts is the closure of facilities due to Medicaid generating less revenue than private insurance; this leaves low-income women with fewer options as the hospitals in areas they live cannot afford to stay open. In an effort to preserve these hospitals, instead of forcing women to look elsewhere, the federal government must introduce legislation-based funding for vulnerable hospitals. Subsidizing this care would allow Medicaid recipients to continue receiving care while simultaneously keeping hospitals afloat.

Finally, expanding the pre-existing Healthy Start program would provide even more services to better protect women and infants. Healthy Start provides funding to state health programs to improve outcomes, particularly in states most affected by maternal health deserts.[61] Expanding the program to accommodate more state facilities and close more gaps in care would likely require a new authorization provided by the federal government. Building on a preexisting program, instead of reinventing a new program or initiative, is likely to be a successful way to gain bipartisan support to increase grant amounts to states.

Underlying all solutions is the need to ensure care that recognizes racial health disparities. Even in counties with adequate healthcare infrastructure, disparities in care also contribute to poor health outcomes. For example, the dismissal of Black patients' concerns about pain or their health is a contributing factor to Black mothers having worse maternal health outcomes.[62] As Allison Bryant, senior medical director for health equity at Mass General in Boston, explains:

> People often criticize the South, while states like California and Massachusetts are commended. But as a health care provider in Boston, where we have a well-resourced health care system, I still

58. *How Can Doulas Help Address Racial Disparities in Care?*, NAT'L HEALTH LAW PROGRAM, https://healthlaw.org/wp-content/uploads/2020/04/DoulasRacialDisparity_4.16.2020.pdf (last accessed Nov. 16, 2024).

59. *See id.*

60. *March of Dimes Report*, *supra* note 23, at 18. This state count includes D.C. *Id.*

61. *See Healthy Start: Nurturing Health, Preventing Disparities*, HRSA MATERNAL & CHILD HEALTH (July 2024), https://mchb.hrsa.gov/programs-impact/healthy-start.

62. Lucy Tu, *Why Maternal Mortality Rates Are Getting Worse Across the U.S.*, SCI. AM. (July 25, 2023), https://www.scientificamerican.com/article/why-maternal-mortality-rates-are-getting-worse-across-the-u-s/.

> see it's not equitable for everyone. We have to look at all disparities, including in states that have great maternal health care at face value.[63]

Creating robust anti-racist policies, procedures, trainings, and awareness campaigns is the only way that addressing maternal health deserts will be successful for *all* women, and that newly established infrastructure, or developments in preserving and maintaining healthcare, will actually serve all women instead of rebuilding inadequate methods or structures.

C. Expanding Medicaid and Eliminating Exclusions

Medicaid could be a powerful tool in low-income women's reproductive care. Expanding Medicaid coverage and eliminating exclusions is the way forward. Because, as previously mentioned, LARCs are often pushed on low-income women, securing long-term care is necessary. Otherwise, this form of birth control could inadvertently leave women without options, should they lose their means of affording to change or alter their birth control method. This would involve a mandatory expansion of Medicaid and necessary safety nets so that individuals do not arbitrarily or suddenly lose access to care. The Medicaid expansion implemented by the Affordable Care Act would help close the current coverage gap. At the time of this Note's publication, ten states have not adopted the Medicaid expansion; these states are predominantly in the South and Midwest, regions with the highest rates of poverty.[64] Without Medicaid expansion, thousands of women are left without any care options, stuck in the coverage gap with seemingly no way out.

Second, as mentioned earlier in this Note, Medicaid must begin to cover doulas and midwives. These services provide more options for women living in areas with limited care options. Funding reimbursement for doulas or including doula and midwifery services within Medicaid coverage is an excellent option for women struggling to find care. As is discussed later, this is not a novel idea, as many states already have the framework necessary to reimburse the cost of doulas or other midwifery services.

In addition to Medicaid expansion, exclusions in Medicaid must be eliminated. The biggest exclusion currently impacting women's reproductive healthcare is the exclusion on utilizing federal Medicaid funds for abortions. While it may seem lofty, an extremely powerful solution would be to repeal the Hyde Amendment. This archaic law has halted the ability of low-income women to receive abortion care if they live in states that do not use their funds to pay for abortions.[65] Litigation strategies to combat the Amendment, coupled with public policy work persuading legislators to take on the issue, could be a path toward

---

63. *Id*.

64. *Status of State Medicaid Expansion Decisions: Interactive Map*, KFF (Nov. 12, 2024), https://www.kff.org/affordable-care-act/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

65. Alina Salganicoff, Laurie Sobel, Ivette Gomez & Amrutha Ramaswamy, *The Hyde Amendment and Coverage for Abortion Services Under Medicaid in the Post-Roe Era*, KFF (Mar. 14, 2024), https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services-under-medicaid-in-the-post-roe-era/.

repealing the law. Until the law is repealed (and even after it is), funding abortions via mutual aid is an important strategy to provide access to care for anyone who needs it.[66]

III. Recommendations

A. LARCs: Ensuring Access Without Imposition

As Dorothy Roberts explains, "We must acknowledge the justice of ensuring equal access to birth control for poor and minority women without denying the injustice of imposing birth control as a means of reducing their fertility."[67] This idea of ensuring equitable access to forms of birth control while still maintaining women's autonomy and decision making must be inherent in all solutions to fix coercive birth control. Solutions regarding LARCs and other forms of birth control focus on less coercive messaging through regulation, provider training, equalization of contraceptive availability, and unified messaging through coalition building.

First, instituting very clear guidelines and rules for the advertisement and prescription of LARCs is essential. With the current weaponization of reproductive autonomy, especially against marginalized women, safeguards must be established against the coercive practices previously outlined.[68] The FDA, through its Office of Women's Health, manages and oversees birth control in the United States[69] and oversees the advertising of prescription drugs.[70] Through this power, the FDA can regulate the messaging individuals receive from advertising generally, and from doctors accompanying a LARC prescription, to ensure this information is not coercive. This creates accountability on the side of the drug producers to create neutral marketing language that does not target specific parties or socioeconomic demographics. The FDA must establish heightened oversight regarding LARC messaging during the review and approval process of their advertisements. Because the FDA is already required to undergo these steps, the implementation of this process is not an arduous burden that would make it unfeasible or costly, which means a greater likelihood of success and less resistance or pushback on the basis of cost.

While the FDA can take action to curb deleterious effects of drug manufacturers, providers themselves play an enormous role in actually prescribing contraceptives to patients. In the past, this dynamic has been abused, with providers

66. For examples of abortion funds successful at ensuring abortion access, see DC Abortion Fund, https://dcabortionfund.org/ (last visited Jan. 2, 2025) and Nat'l Network of Abortion Funds, https://abortionfunds.org/ (last visited Jan. 2, 2025).

67. Roberts, *supra* note 11, at 56–57.

68. *See supra* Section I.A.

69. *See* U.S. Food & Drug Admin., Birth Control Chart (2024), https://www.fda.gov/consumers/womens-health-topics/birth-control.

70. U.S. Food & Drug Admin., Prescription Drug Advertising – Questions and Answers (2015), https://www.fda.gov/drugs/prescription-drug-advertising/prescription-drug-advertising-questions-and-answers.

sometimes insisting that low-income women should choose a LARC over another birth control method simply based on their income level, with no regard to which birth control method may actually be best for their health and interests.[71] Providers are likely not intending to be malicious; but it's very likely that longstanding historical stigma and biases influence their decisions and ideas about who LARCs should be promoted to.[72] Trainings geared toward educating health professionals or clinic staff on patient autonomy and choice regarding birth control are essential to protect low-income women. The University of California San Francisco's "Beyond the Pill" program aims to "[promote] access and equity in contraceptive health care" in part by providing trainings for health professionals.[73] The trainings cover topics like best practices for providing a full range of contraceptive options for patients, reproductive justice and patient-centered counseling, and include information about gender diverse patients.[74] Trainings like these that highlight the dangers of defaulting to a type of birth control—instead of utilizing a patient-centered approach—can better equip providers serving low-income women to actually address their needs rather than applying a one-size-fits-all solution.

Additionally, equalizing access to all types of birth control takes the pressure off women to think they must use LARCs. In their aforementioned study, KFF highlighted that more and more states are allowing twelve-month doses of oral contraceptives to be dispensed at a time.[75] This extended supply is associated with "better access and lower rates of unplanned pregnancy" as opposed to restricted doses (month-to-month or three-month).[76] However, only eighteen states dispense twelve-month doses of oral contraceptives, meaning that crossing state lines can dramatically change one's access.[77] Under Medicaid, expanded or non-expanded, services should be standardized across states to accomplish the highest rates of access. Instead of state coverage being equalized to, say, the average form of coverage, all state services must match the highest level of access. To do this, utilization controls—which allow states to alter how they prescribe medication

71. *See* Cappello, *supra* note 11, at 38–39. Throughout this Note the emphasis on choosing between methods of birth control has been made clear. It is important to note, particularly for individuals who have little to no experience with birth control methods, that different birth control methods have various side effects—for many women, a specific form of birth control may not be useable due to underlying conditions (like bleeding risks), anatomy, previous traumas, or lifestyle. Ensuring that *all* women, not just wealthy women, get to choose their *preferred* method of birth control is necessary to ensure that women have access to methods that work *for them*, not just methods that work *generally*. *See, e.g.*, *Birth Control Options*, CLEVELAND CLINIC, https://my.clevelandclinic.org/health/articles/11427-birth-control-options (last visited Sept. 22, 2024).

72. *See* Cappello, *supra* note 11, at 38 (describing biases held by both clinicians and policymakers when advocating for and promoting LARC use specifically among marginalized communities).

73. BEYOND THE PILL, https://beyondthepill.ucsf.edu/(last visited May 18, 2024).

74. *Id.* (choose "Our Work"; then choose "Our Training"; then choose "Explore our curriculum offerings").

75. Ranji et al., *supra* note 50.

76. *Id*.

77. *Id.* See the associated Figure 4 created by the KFF survey for a map of each state's coverage or lack thereof.

under Medicaid, like implementing quantity or age restrictions[78]—should be eliminated and regulatory guidelines promoting access to twelve-month doses should be established. The same way that Medicaid imposes certain requirements on states, the Centers for Medicare & Medicaid services can implement new guidelines for states that require standardization of oral contraceptive coverage and prescription so that states with poor access must improve to meet the standards of states with the highest access.

Finally, coalition building on this issue would help to clarify concerns and include low-income women in conversations regarding contraceptives and reproductive autonomy. Many reproductive health and justice organizations struggle to articulate the idea of LARC coercion because restrictions on reproductive healthcare have historically been driven by anti-choice proponents who would rather see a decrease in overall birth control options. But by taking control of the conversation, reproductive justice organizations can ensure that the necessary conversations are taking place without creating damaging effects on overall access. Organizations like NARAL (now Reproductive Freedom for All), Planned Parenthood, National Women's Law Center, and the Center for Reproductive Rights, among others, should engage in research, release organized statements, and work with access-to-justice or poverty specialists to specifically address low-income women's experiences with access to care and the coercive rhetoric used by providers and policymakers. This would require the organizations to come together in agreeance on this nuanced issue and would demand the participation of medical providers and anti-poverty advocates to ensure accurate, inclusive information. Additionally, creating detailed, thoughtful responses to the history of coercive and abusive practices and paths forward that remain cognizant of said history can equip policymakers with necessary language and foundation for policy goals dealing with access to care or financing. For example, Reproductive Freedom for All has a section on their website titled "Learn" where users can read blog posts and memos on a variety of topics.[79] Short-form pieces like these that reach a wide audience are a useful platform for starting this discussion and can enable further conversations about LARCs that recognize the past while pushing for an equitable future.

B. Funding and Expansion of Maternal Health

Solving the problem of maternal health deserts involves a three-pronged approach: funding rural healthcare and subsidizing facilities that rely on Medicaid, investing in doulas and midwifery, and expanding Healthy Start.

First, funding areas where healthcare is vulnerable and subsidizing much needed care to keep facilities running and able to serve low-income rural women is imperative. President Biden's American Rescue Plan created emergency Rural Health Care Grants to ensure that facilities survived the COVID-19 pandemic and

78. *Id.*

79. *Learn*, REPRODUCTIVE FREEDOM FOR ALL, https://reproductivefreedomforall.org/learn/ (last visited May 18, 2024).

had funds to help with vaccination and treatment.[80] In 2023, grants were still being awarded; $129 million were awarded to 172 rural health organizations across the fifty states.[81] Rural Health Care Grants must persist. To ensure that this funding source is protected and solidified as a yearly grant, the Rural Health Care Grant program must become a permanent budgetary fixture implemented by the President and requested by the United States Department of Agriculture (USDA). In the FY2025 Budget, the USDA requested $29.2 billion for their various programs.[82] The Department of Defense requested $849.8 billion.[83] Reallocating $129 million from Defense to the USDA to fund the program would provide the money necessary in the budget to keep Rural Health Care Grants and leave Defense projects virtually unaffected, considering the almost $1 trillion price tag.[84]

Second, investing in doulas and midwives and including them as a viable alternative increases the options (specifically, culturally competent and patient-centered options) available to women. President Biden's Budget also included funding for doulas in the healthcare improvement allocation, allotting $6 million in 2025 and additional money each subsequent year.[85] This funding must be used to support doula reimbursement and efforts to attain reimbursement or funding for services in states that currently do not provide it. Additionally, keeping this funding in federal budgets moving forward ensures that doula access remains expanded. The National Health Law Program (NHeLP) created a Doula Medicaid Project that tracks state and federal actions geared toward expanded access.[86] Most states either actively reimburse or have implementation efforts in progress; however, for the states that do not, organizations like NHeLP should engage in active communication with policymakers about the benefits of doula services and their impact on maternal mortality.[87] Additionally, federal bills seeking to amend the Social Security Act to provide coverage for doula services have

---

80. *Biden-Harris Administration Helps Expand Access to Rural Health Care Through Investing in America Agenda*, U.S. DEPT. OF AGRIC. (July 25, 2023), https://www.usda.gov/media/press-releases/2023/07/25/biden-harris-administration-helps-expand-access-rural-health-care.

81. *Id.*

82. OFF. OF MGMT. & BUDGET, BUDGET OF THE U.S. GOVERNMENT: FISCAL YEAR 2025 at 169 [hereinafter FEDERAL BUDGET FY25].

83. *Id.*

84. To put these numbers into a tangible perspective, a 2020 model F-35A Joint Strike Fighter—an Air Force stealth fighter jet manufactured by Lockheed Martin—costs the Federal Government around $110 million each. *See* Dan Grazier, *Selective Arithmetic to Hide the F-35's True Costs*, PROJECT ON GOV'T OVERSIGHT (Oct. 21, 2020), https://www.pogo.org/analysis/selective-arithmetic-to-hide-the-f-35s-true-costs. In May 2024, the Air Force had plans to purchase 1,800 additional F-35As. *See The F-35 Will Now Exceed $2 Trillion As the Military Plans to Fly It Less*, GOV'T ACCOUNTABILITY OFF. (May 16, 2024), https://www.gao.gov/blog/f-35-will-now-exceed-2-trillion-military-plans-fly-it-less. Buying *two fewer* F-35As would provide the funds to pay for the Rural Health Care Grant annually.

85. FEDERAL BUDGET FY25, *supra* note 82, at 82, 148.

86. *Doula Medicaid Project*, NAT'L HEALTH L. PROGRAM, https://healthlaw.org/doulamedicaidproject/#current-efforts-at-expanding-access-to-doula-care (click "Current State Efforts" to view spreadsheet) (tracking spreadsheets last updated Nov. 2024).

87. *See id.*

been proposed.[88] More support from federal legislation like these examples is instrumental to ensure that doula coverage remains a permanent part of the SSA so that it receives annual, uninterrupted funding.

Finally, securing and even expanding Healthy Start would further close the access gap present in maternal health deserts. In FY2025, Healthy Start was allocated over $105 million which it dispersed across several states, many being southern, rural states in desperate need of funding.[89] This funding was inspired by the *White House Blueprint for Addressing the Maternal Health Crisis*, which received an overall $376 million allocation by President Biden in the FY2025 Budget.[90] Keeping this allocation in the federal budget is crucial, and the way to secure permanent funding might be in the form of federal legislation. Policies creating permanent funding allotments for the Healthy Start program, while also explaining and emphasizing its importance in improving maternal health outcomes for low-income women, may help to secure the funding and make it immune to changing administrations. In the future, Healthy Start may need additional funds to meet the needs of a growing and changing population. Increasing the award amount of Healthy Start by $100 million would expand the reach of the program and enable more states and communities to receive necessary funding.

As mentioned above, pulling money in from Defense spending could accomplish this. But another funding source could come from taxing high-powered, profitable corporations. For example, in 2021, AT&T paid little to no federal income taxes despite earning $29.6 billion in revenue.[91] Taxing these corporations would raise significant funds, well beyond what is needed to accomplish the asserted strategies for combating maternal health deserts. Tax policy may be the way forward to achieving tremendous change for vulnerable, low-income women across the country. The National Women's Law Center's recent campaign to fund care investments and other anti-poverty measures, called "Tax the Patriarchy," demonstrates that tax policy is a viable way to generate the revenue needed to fund these expenditures.[92]

---

88. *See, e.g.*, Mamas First Act, H.R. 8317, 118th Cong. (2024).

89. *FY 2024 Healthy Start Awards*, HRSA MATERNAL & CHILD HEALTH (Apr. 2024), https://mchb.hrsa.gov/programs-impact/healthy-start/fy-2024-awards.

90. FEDERAL BUDGET FY25, *supra* note 82, at 21.

91. Ryan Koronowski, Jessica Vela, Zahir Rasheed & Seth Hanlon, *These 19 Fortune 100 Companies Paid Next to Nothing—or Nothing at All—in Taxes in 2021*, CTR. AM. PROGRESS (Apr. 26, 2022), https://www.americanprogress.org/article/these-19-fortune-100-companies-paid-next-to-nothing-or-nothing-at-all-in-taxes-in-2021/.

92. *Tax the Patriarchy*, NAT'L WOMEN'S L. CTR., https://nwlc.org/resource/ttp/ (last visited Nov. 16, 2024); *Tax the Patriarchy: Investments to Advance Gender and Racial Justice*, NAT'L WOMEN'S L. CTR. (Dec. 5, 2023), https://nwlc.org/resource/tax-the-patriarchy-investments-to-advance-gender-and-racial-justice/; *see also* DEP'T OF TREASURY, GENERAL EXPLANATIONS OF THE ADMINISTRATION'S FISCAL YEAR 2024 REVENUE PROPOSALS 211 (2023), https://home.treasury.gov/system/files/131/General-Explanations-FY2024.pdf (raising the corporate income tax, for example, could raise millions of dollars per year).

C. Overhauling Medicaid

One of the biggest issues facing low-income women is the coverage gap, brought on by the non-expansion of Medicaid. Expanding Medicaid must become a top priority for policymakers; persuading state legislators to pass expansion bills or include expansion as an initiative on ballots and listening to organizers on the ground fighting for these changes is crucial. For example, in February 2024, Florida organizers created a campaign to add Medicaid expansion to the 2026 ballot.[93] These initiatives could prove to be extremely successful, given that Medicaid is quite popular among the general population; a 2023 poll found that around 76% of individuals had a favorable view of Medicaid.[94] Additionally, Medicaid expansion itself is popular, with two-thirds of those in non-expansion states wanting their state to expand Medicaid.[95] With these numbers in mind, state-level ballot initiatives instigated by citizens or state policymakers have the chance to be successful. While states differ on whether they allow individuals to propose issues on an upcoming ballot, organizing efforts can still promote change by inspiring either voters or state governing bodies to take up the issue.

However, putting an initiative on the ballot, without any information or education, may do nothing to advance the cause. In tandem with ballot initiatives, there must also be an effort to educate voters on what Medicaid expansion would mean for them and their state. Reaching voters of all kinds can take a variety of forms, from awareness campaigns by Democratic organizations to work by congressmen and women from affected states broadcasting their support to their constituents. Organizations like the KFF and the National Health Law Program should continue to inspire action in states through policy work directed either at state legislators or constituents.

Finally, efforts to repeal the Hyde Amendment must continue. Congresswomen like Ayanna Pressley have already started efforts to repeal the Amendment, introducing the Equal Access to Abortion Coverage in Healthcare (EACH) Act to end the Hyde Amendment.[96] The bill was introduced in 2023. But because repealing the Amendment seems somewhat out of reach in the present moment, and low-income women need abortions *now*, bolstering abortion funds is critical. Abortion funds are "organizations that directly support people seeking abortions" by providing money for procedures, arranging travel, and coordinating details for an individual to receive

---

93. *See Status of State Medicaid Expansion Decisions: Interactive Map*, *supra* note 64.

94. *See 5 Charts About Public Opinion on Medicaid*, KFF (Mar. 30, 2023), https://www.kff.org/medicaid/poll-finding/5-charts-about-public-opinion-on-medicaid/(analyzing, in Figure 2, individuals' opinions of Medicaid, where 76% of respondents indicated that they had a very or somewhat favorable view of Medicaid).

95. *Id.*

96. *See Pressley, Lee, DeGette, Schakowsky Unveil EACH Act for Reproductive Justice*, CONGRESSWOMAN AYANNA PRESSLEY (Jan. 26, 2023), https://pressley.house.gov/2023/01/26/pressley-lee-degette-schakowsky-unveil-each-act-for-reproductive-justice/.

an abortion.[97] Essentially, an abortion fund seeks to remove the barriers that make getting an abortion seem impossible; for poor women, this takes the form of monetary and stability supports that allow them to travel, if necessary, to receive the care they need. The D.C. Abortion Fund and the National Network of Abortion Funds are successful funds that enable low-income women to gain access to abortion care.[98] These funds accept donations from the general public to fund care and create and disseminate invaluable resources and information. In D.C. for example, the Fund frequently hosts events, recruits volunteers, and builds partnerships with local businesses, allowing people to donate money or receive funds for an abortion, enabling it to simultaneously sustain itself and accomplish its goal of providing abortion access.[99] In this way, community organizing around providing abortions works to reach vulnerable populations. Expanding abortion funds to every state, particularly those with large low-income populations or those that do not utilize their own state funds to finance abortions, creates a community-based solution that enables abortion access.

Conclusion

Bryan Stevenson reminds, "the opposite of poverty is not wealth; the opposite of poverty is justice."[100] In the context of accessing healthcare, this idea rings true. Solving problems of access to care for women does not simply mean improving literal routes to access; it also means analyzing and combatting the deeper-rooted problems of biases, discrimination, and poverty. Only then will women finally have true access to holistic care to improve their health and wellbeing. Whether the solutions lie in legislative actions, interest group organizing, or community-based care models, understanding the unique needs and problems faced by low-income women is crucial. Only then can we ensure that low-income women receive the non-coercive gender-based care that they need–care that alleviates their pains, care that keeps them with their families, and care that improves their lives so they finally get the justice they deserve.

97. *Fast Facts About Abortion Funds*, Nat'l Network of Abortion Funds, https://abortionfunds.org/abortion-funds-fast-facts/(last visited Sept. 22, 2024).

98. For more information, access their websites at https://dcabortionfund.org/ and https://abortionfunds.org/, respectively.

99. *See* DC Abortion Fund, https://dcabortionfund.org/ (last visited Jan. 2, 2025).

100. Bryan Stevenson, Just Mercy 15 (2014).