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Prosecuting Women for Drug Use During Pregnancy: The Criminal Justice System Should Step Out and the Affordable Care Act Should Step Up

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PROSECUTING WOMEN FOR DRUG USE DURING PREGNANCY: THE CRIMINAL JUSTICE SYSTEM SHOULD STEP OUT AND THE AFFORDABLE CARE ACT SHOULD STEP UP

Erin D. Kampschmidt[†]

CONTENTS

INTRODUCTION.....	487
I. SUBSTANCE ABUSE AND PREGNANCY	490
A. <i>The Numbers</i>	491
B. <i>Growing Use of Opiates by Pregnant Women</i>	492
C. <i>Effects of Drug Abuse During Pregnancy on the Fetus</i>	494
II. CRIMINAL JUSTICE.....	496
A. <i>A Brief History of Fetal Protection Laws in the United States</i>	496
B. <i>Criminal Law Theory</i>	498
C. <i>Prosecution of Pregnant Drug Users Does Not Fit Within the Justifications for Criminal Punishment</i>	500
III. SUBSTANCE USE DISORDER TREATMENT	504
IV. THE AFFORDABLE CARE ACT.....	506
A. <i>Potential Solution</i>	506
1. <i>Essential Health Benefits and Coverage Parity</i>	507
2. <i>Integration of Care</i>	509
B. <i>Challenges and Recommendations</i>	510
CONCLUSION.....	512

INTRODUCTION

For nearly three and a half decades, the actions of soon-to-be mothers have been under the watchful eye of state prosecutors. The

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first criminal charges brought against a woman for using drugs during pregnancy came in 1977 against Margaret Reyes.¹ Reyes was charged with two counts of felony child endangerment for her heroin use during pregnancy, but the charges were later dropped because the California Court of Appeals declared that the statute was never intended to extend to unborn children.² The Court of Appeals enjoined all further prosecution.³

Criminal prosecutions of women for drug use during pregnancy reappeared in the 1980s with the introduction of cocaine to the U.S. market.⁴ The late 1980s saw an increase in drug charges and punishments, including those against pregnant women.⁵ Although no state has enacted a law that specifically criminalizes conduct during pregnancy,⁶ cases have been brought under theories of child endangerment, child abuse, delivery of drugs to a minor via the placenta or umbilical cord, and eventually under theories of homicide, manslaughter, and attempted murder.⁷

Currently, South Carolina and Alabama are the only states to uphold criminal prosecutions for the actions of women during pregnancy.⁸ Most famously, South Carolina sentenced Regina

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1. *Reyes v. Super. Ct.*, 141 Cal. Rptr. 912, 912-13 (Ct. App. 1977); Linda C. Fentiman, *In the Name of Fetal Protection: Why American Prosecutors Pursue Pregnant Drug Users (and Other Countries Don't)*, 18 COLUM. J. GENDER & L. 647, 648 (2009).
 2. FENTIMAN, *supra* note 1.
 3. *Reyes*, 141 Cal. Rptr. at 913-14.
 4. *Timeline: America's War on Drugs*, NPR (Apr. 2, 2007), <http://www.npr.org/templates/story/story.php?storyId=9252490>.
 5. *Id.*; Barry M. Lester & Jean E. Twomey, *Treatment of Substance Abuse During Pregnancy*, 4 WOMEN'S HEALTH 67, 68 (2008) ("The development of treatment programs for drug-using pregnant women surged as a result of the 'cocaine epidemic' of the 1980s.").
 6. *Punishing Women for Their Behavior During Pregnancy: An Approach That Undermines Women's Health and Children's Interests*, CTR. FOR REPROD. RIGHTS 2 http://reproductiverights.org/sites/default/files/documents/pub_bp_punishingwomen.pdf.
 7. See Victoria J. Swenson & Cheryl Crabbe, *Pregnant Substance Abusers: A Problem That Won't Go Away*, 25 ST. MARY'S L.J. 623, 640-45 (1994) (presenting criminal prosecution attempts under statutes for criminal child protection, the delivery of drugs to a minor, and possession of a controlled substance); BONNIE STEINBOCK, *LIFE BEFORE BIRTH* 168-175 (2d ed. 2011).
 8. Though not a criminal action, Wisconsin has enacted legislation allowing the court to civilly commit a pregnant woman for drug use until she is no longer a risk to others, mainly the fetus. WIS. STAT. ANN. §§ 51.15 & 51.20 (West 2013).

McKnight to twenty years in prison for homicide by child abuse.⁹ McKnight, a “homeless African-American woman with an IQ of seventy-two and an addiction to crack cocaine,”¹⁰ gave birth to a stillborn baby with an estimated fetal age of thirty-four to thirty-seven weeks.¹¹ Autopsy revealed that the baby died *in utero* two days prior to McKnight going into labor and had cocaine in its system.¹² McKnight was charged with murder based on the finding of cocaine in the baby’s system as the cause of death.¹³

While these two southern states are the only states to continually uphold convictions of pregnant drug users, a large number of state prosecutors across the nation continue to bring cases despite the fact that the majority of cases are overturned on appeal.¹⁴ Although laws in some states have been changed recently to protect pregnant women from prosecution,¹⁵ the law in general has become outdated by current data on drug abuse and patient needs, as well as by recent developments in federal legislation aimed at health care.

The Patient Protection and Affordable Care Act (ACA) provides the best solution to the issue of substance abuse during pregnancy.¹⁶ The ACA enables women to have coverage for substance abuse treatment within an integrated health system focused on the overall

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9. State v. McKnight, 576 S.E.2d 168 (2003). Upon a finding of inadequate counsel and inappropriate jury instruction, but no violation of the Equal Protection Clause, McKnight was released in 2008 after serving eight years in prison. McKnight v. State, 661 S.E.2d 354 (2008).
 10. Linda C. Fentiman, *Pursuing the Perfect Mother: Why America’s Criminalization of Maternal Substance Abuse is Not the Answer: A Comparative Legal Analysis*, 15 MICH. J. GENDER & L. 389, 402 (2009).
 11. McKnight, 576 S.E.2d at 171 (2003).
 12. *Id.*
 13. FENTIMAN, *supra* note 10, at 402.
 14. See FENTIMAN, *supra* note 1, at 661 (arguing that state prosecutors continue to bring charges against pregnant drug users for selfish reasons, *i.e.* to bring in votes from non-empathetic citizen).
 15. Phillip Smith, *New Jersey Supreme Court Protects Rights in Pregnancy Case*, STOPTHEDRUGWAR.ORG, (Feb. 7, 2013), http://stopthedrugwar.org/chronicle/2013/feb/07/new_jersey_supreme_court_protect; N. J. Dep’t of Children & Families, Div. of Youth & Family Servs. v. A.L., 213 N.J. 1 (3d Cir. 2013) (overruling district and appellate court decisions which found that the state’s child endangerment laws could be applied to a fetus *in utero*, thus declaring that one positive drug test while pregnant does not establish proof of imminent danger or substantial risk of harm).
 16. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.).

health of mother and baby. This solution will only be truly functional if the criminal justice system steps out of the way, thus allowing pregnant women to see the doctor without the fear of jail time.¹⁷

This Note presents the issue of substance abuse during pregnancy, the mistreatment of the issue as a criminal matter, the proper method of handling the issue, and a solution to the problem through current legislation. Part I of this Note contains statistical information on the number of women who admit to substance abuse while pregnant, the growth of prescription opiate abuse, and the harm caused to the fetus due to substance abuse *in utero*. Part II briefly describes the history of the fetal protection laws aimed at pregnant drug users followed by a description of the policy rationales and justifications for treating substance abuse during pregnancy as a criminal matter. Further, Part II explains why criminal justifications do not support the treatment of substance use during pregnancy as a crime. Part III examines the proper method of handling the problem of substance abuse during pregnancy—namely, rehabilitation through substance use disorder treatment with integrated prenatal care—and current challenges. Finally, based on the evidence presented, Part IV concludes that the proper remedy to achieve the goals of the fetal protection laws is to remove the issue from the criminal justice system and instead rely on the support of the community and treatment options made newly available thanks to the ACA's requisite essential health benefits coverage. Utilizing these benefits, women suffering from substance use disorders will be able to seek out treatment in conjunction with prenatal care thus providing the optimal opportunity for both mother and baby to be healthy.

Although the following topics are important to a full analysis of criminal laws aimed at pregnant drug users, this Note does not focus on the constitutional validity of those laws, nor does it focus on issues of racial or sexual discrimination, violation of reproductive rights, or prosecutorial prejudice, though these topics may take a supporting role in the argument. Instead, this Note makes a policy argument that can act as a compromise for the fight between a mother's and a fetus's rights and protections from harm while dismissing the false pretenses on which the current criminal laws against pregnant drug users stand.

I. SUBSTANCE ABUSE AND PREGNANCY

The following material provides background information necessary for a full understanding of the topic of substance abuse during pregnancy. The first subsection provides statistics on the number of

17. See *infra* Part IV.B.

women using illicit drugs during their pregnancy. The second subsection discusses the rise of the use of legal opiates during pregnancy. Finally, the third section explains the current knowledge of the effects drug use during pregnancy has on the fetus. An understanding of this material is crucial to a complete appreciation of the issue and the evidentiary support for fetal protection laws.

A. *The Numbers*

The fetal protection laws introduced in the 1980s were intended to deter women from using drugs during pregnancy by inducing fear of criminal prosecution.¹⁸ However, statistics gathered from national surveys indicate that the number of pregnant women using drugs is currently on the rise.¹⁹ The Substance Abuse and Mental Health Services Administration, a division of the Department of Health and Human Services, releases biannual reports of drug use in the United States.²⁰ Included in these reports is data on the use of illicit drugs by pregnant women. During the years of 1994-1995, nearly a decade since the introduction of the fetal protection laws, 2.3 percent of pregnant women were current drug users.²¹ The *National Survey on Drug Use and Health* reveals that “[a]mong pregnant women aged 15 to 44, 5.9 percent were current illicit drug users” during the years 2011 and 2012.²² When broken up according to age range, “[t]he rate of current illicit drug use . . . was 18.3 percent among pregnant women aged 15 to 17, 9.0 percent among pregnant women aged 18 to 25, and 3.4 percent among pregnant women aged 26 to 44.”²³ When further

18. See DEPT. HEALTH & HUM. SERVS., SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., RESULTS FROM THE 2012 NATIONAL SURVEY ON DRUG USE AND HEALTH: SUMMARY OF NATIONAL FINDINGS 23 (Sept. 2013) [hereinafter 2012 SAMHSA Survey], (data averaged across 2011 and 2012).

19. *Id.* at 1.

20. See generally SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <http://www.samhsa.gov> (last visited Apr. 9, 2015).

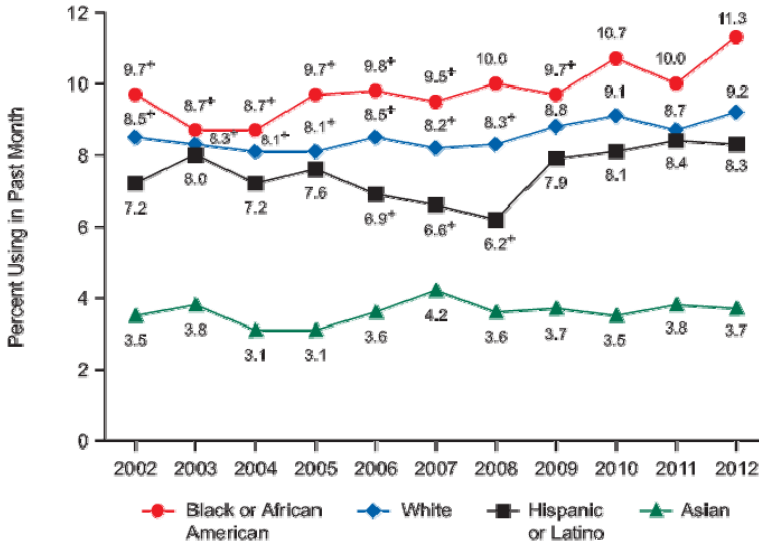
21. DEPT. HEALTH & HUM. SERVS., SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., OFFICE OF APPLIED STUDIES, *National Household Survey on Drug Abuse Advance Report # 18: Women of Childbearing Age*, Aug. 1996 (“To allow more detailed analyses to be done, data from the 1994 and 1995 NHSDAs were combined, providing a sample of 761 pregnant and 14,233 nonpregnant [sic] women age 15-44.”).

22. 2012 SAMHSA Survey, *supra* note 18, at 23.

23. Data for both of these studies was collected by the federal government through face-to-face interviews and is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), and U.S. Department of Health and Human Services. The survey fails to collect data on a large group of homeless individuals characterized by substance abuse because they were excluded based on the methodology of data

broken down by ethnic group, the data indicate that drug abuse during pregnancy is most prevalent among African American women.²⁴

Figure 1. Drug abuse during pregnancy.²⁵



These statistics reveal that the number of women who identify as pregnant drug users has significantly increased in the past fifteen years, despite the fact that these women could be criminally charged for their actions in several states at the time the reports were published.

B. Growing Use of Opiates by Pregnant Women

In addition to information on the percentage of American women who admit to using drugs during pregnancy, statistical information can be gathered based on the number of infants born annually suffering from symptoms of withdrawal from opiates. Because most women would not consider prescription painkillers or other prescription drugs derived from opium to be drugs necessary to report

collection (door-to-door interviews of homeowners and renters); therefore, the numbers are likely greater in reality than reported. Nevertheless, the surveys use consistent methods and reveal an increase in the number of women who report using drugs or other substances during pregnancy. *Id.* at 119.

24. *Id.*; *id.* at Figure 2.12.

25. *Id.* at Figure 2.12.

for the *National Survey on Drug Use*,²⁶ information on opiate withdrawal symptoms in infants reveals additional women using potentially harmful drugs while pregnant.

Tennessee is the first state to require reporting of withdrawal from opiates,²⁷ a condition known as neonatal abstinence syndrome (NAS), although no federal government agency tracks NAS cases.²⁸ In 2013, the Tennessee Department of Health called NAS an “epidemic” and estimated at least 800 cases of NAS in Tennessee for the year.²⁹ In Wilmington, North Carolina at New Hanover Regional Medical Center, the number of newborns treated or monitored for drug withdrawal shot up 119 percent in three years, from thirty-one cases in 2009 to sixty-eight during 2012.³⁰

Nationally, the figures are also rising. In a retrospective study measuring the national health care expenditures associated with NAS, it was found that from 2000 to 2009 that the incidence of NAS among newborns increased from 1.20 to 3.39 per 1000 hospital births per year.³¹ The incidence of antepartum maternal opiate use increased from 1.19 to 5.63 per 1000 hospital births per year.³²

The increase in incidence of NAS has occurred fairly dramatically and is the result of mothers taking legal painkillers and other drugs that are derivatives of opium.³³ “New data from Tennessee show that 42 percent of mothers of drug-dependent newborns used only substances prescribed for legitimate treatment. Another 30 percent used illegal drugs and about 20 percent used a mix of both.”³⁴ While

26. *Id.* at 75.

27. Other drugs have been indicated to result in NAS, specifically heroin and methadone. Stephen W. Patrick et al., *Neonatal Abstinence Syndrome and Associated Health Care Expenditures United States, 2000-2009*, 307 JAMA 1934, 1934 (2012).

28. JoNell Aleccia, ‘Just Flooding Us’: Tenn. Spike in Drug-Dependent Newborns is Warning to Nation, NBC NEWS, Oct. 11, 2013, <http://www.nbcnews.com/health/just-flooding-us-tenn-spike-drug-dependent-newborns-warning-nation-8C11375654>.

29. *Id.*

30. Brian Freskos, *Hospitals Work to Wean Babies Addicted to Drugs*, STAR NEWS ONLINE (July 21, 2013), <http://www.starnewsonline.com/article/20130721/ARTICLES/130719582?template=printpicart>.

31. PATRICK ET AL., *supra* note 27.

32. *Id.*

33. See AM. COLL. OF OBSTETRICS & GYNECOLOGY, COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN & THE AM. SOC’Y OF ADDICTION MED., COMM. OPINION: OPIOID ABUSE, DEPENDENCE, AND ADDICTION IN PREGNANCY 1 (May 2012) [hereinafter ACOG 2012 Opinion].

34. ALECCIA, *supra* note 28.

painkillers are legal, they are highly addictive and can be dangerous to quit without supervision by a medical professional.³⁵

The focus of fetal protection laws is illicit drugs, not prescription drugs obtained legally by a pharmacist. However, “prescription drugs are the second-most abused category of drugs after marijuana.”³⁶ As explained in the following section, prescription drugs derived from opium may be extremely harmful to the fetus, but the criminal laws targeting illicit drugs do not meet the intended goal of deterring women from taking these medications because they are legally obtained.

C. *Effects of Drug Abuse During Pregnancy on the Fetus*

Expert opinion straddles both sides of the spectrum regarding the long-term medical effects that drug use has on the fetus. Doctors and advocacy groups around the nation argue that the long-term effects of drug use during pregnancy on the fetus are not fully known; therefore, punishment should not be based on such an unsupportable justification.³⁷

Fetal impact studies investigate the developmental impact of drug abuse during pregnancy on the fetus while *in utero*, postpartum, and throughout development into adulthood.³⁸ The studies compare the babies of women who used drugs during pregnancy to babies of women who did not use drugs during pregnancy.³⁹ Fetal impact studies focus on a variety of medical issues in the newborn period, including (1) fetal growth, (2) congenital anomalies, (3) withdrawal, (4) neurobehavioral abnormalities, and (5) breastfeeding.⁴⁰ Long-term

35. *See id.*; ACOG 2012 Opinion, *supra* note 33.

36. Office of Nat’l Drug Control Pol’y, *Prescription Drug Abuse*, THE WHITE HOUSE, *available at* <http://www.whitehouse.gov/ondcp/prescription-drug-abuse> (last visited Mar. 25, 2015).

37. *See* Adam Nossiter, *In Alabama, A Crack Down on Pregnant Drug Users*, N.Y. TIMES, Mar. 15, 2008, <http://www.nytimes.com/2008/03/15/us/15mothers.html?emc=eta1&r=0>; *see also* JOHN P. MORGAN & LYNN ZIMMER, *CRACK IN AMERICA: DEMON DRUGS AND SOCIAL JUSTICE* 151 (Craig Reinerman & Harry G. Levine eds., 1997); ACOG 2012 Opinion, *supra* note 33, at 5; SWENSON & CRABBE, *supra* note 7, at 653 (discussing the views of the American Medical Association and the National Association of Public Child Welfare Administrators).

38. *See generally* MORGAN & ZIMMER, *supra* note 37; Marylou Behnke & Vincent C. Smith, *Prenatal Substance Abuse: Short- and Long-Term Effects on the Exposed Fetus*, 131 PEDIATRICS e1009, e 1009 (2013).

39. MORGAN & ZIMMER, *supra* note 37, at 150.

40. BEHNKE & SMITH, *supra* note 38, at e1012-14.

effects resulting from prenatal drug exposure can be recognized through (1) growth, (2) behavior, (3) cognition/executive function, (4) language, (5) achievement, and (6) predisposition to drug use.⁴¹

The summary report of previous fetal impact studies by Behnke & Smith recognized that the strongest effects on fetal development are associated with alcohol abuse and that the most significant effect of opiate use was NAS.⁴² There is no consensus on the effects of cocaine or marijuana, and studies on the effects of methamphetamine are still in their infancy.⁴³

While it is known that babies born with NAS suffer from excruciating pain, causing the infants to be “inconsolable, cry and sweat excessively, have diarrhea, stiff limbs, vomiting and sometimes seizures,”⁴⁴ there exists little definitive research on whether NAS harms the long-term health or developmental outcomes of the infant.⁴⁵ Nevertheless, some studies conclude that NAS is associated with low birth weights and mortality.⁴⁶

There has been significant criticism of the methodology behind fetal impact studies because the participants are overwhelmingly from poor and minority groups.⁴⁷ This means that they are less likely to have “had adequate nutrition and medical care during their pregnancies and [are] less likely to have healthy babies, whether they use cocaine or not.”⁴⁸ The results are further complicated by “the fact that poor pregnant women who use cocaine are more likely than pregnant women generally to have an infectious disease” or other conditions that may contribute to negative findings.⁴⁹

Fetal impact studies have questionable justificatory application due to their methodological problems and confounding variables.⁵⁰ Because the criminalization of pregnant drug users relies so heavily on the premise that fetuses must be protected from the harm that substance abuse will cause them *in utero*, medical evidence must back such a theory. For that reason, on appeal, the court in McKnight’s case acknowledged that expert medical testimony adequate to win the

41. *Id.* at e1014-16.

42. *Id.*

43. *Id.*

44. FRESKOS, *supra* note 30.

45. *Id.*

46. *See* PATRICK ET AL., *supra* note 27.

47. MORGAN & ZIMMER, *supra* note 37, at 150.

48. *Id.*

49. *Id.*

50. *Id.*

appeal for McKnight should include “recent studies showing that cocaine is no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor.”⁵¹

II. CRIMINAL JUSTICE

Evidence is resounding that women continually and increasingly are using drugs while pregnant, be they legal or illegal substances.⁵² Although the medical evidence is questionable as to the short- and long-term impact of *in utero* drug use on the fetus,⁵³ some criminal prosecutors and judges view criminal punishment as the ideal method to address the problem of drug use during pregnancy.⁵⁴

A. *A Brief History of Fetal Protection Laws in the United States*

Cases against women for their actions during pregnancy have been brought in thirty states.⁵⁵ As of 2009, estimates relying on court documents, news stories, and attorney data show that at least 200 pregnant and parenting women have been arrested and subsequently charged for alleged drug use during pregnancy.⁵⁶ But these estimates appear to be grossly underestimating the true numbers. For instance, in just one eighteen-month period between 2006 and 2008, at least eight women were prosecuted for using drugs while pregnant in a rural jurisdiction of Alabama with barely 37,000 residents.⁵⁷ A majority of the cases are brought against women of color, many of whom are under-educated, poor, sexually and physically abused, and mentally disabled.⁵⁸ Due to their childhood home environment and

51. Diana Kasdan, *Victory in the Regina McKnight Case*, ACLU, BLOG OF RIGHTS (May, 15, 2008), <https://www.aclu.org/blog/reproductive-freedom/victory-regina-mcknight-case>; *McKnight*, 661 S.E.2d at 358.

52. *See supra* Sections I.A-B.

53. *See supra* Section I.C.

54. *See* SWENSON & CRABBE, *supra* note 7, at 636.

55. Linda C. Fentiman, *Rethinking Addiction: Drugs, Deterrence and the Neuroscience Revolution*, 14 U. PA. J.L. & SOC. CHANGE 233, 237 (2011). For a comprehensive list of all cases through 2009, *see* FENTIMAN, *supra* note 10, at 466-69.

56. CTR. FOR REPRO. RIGHTS, *supra* note 6.

57. NOSSITER, *supra* note 37.

58. FENTIMAN, *supra* note 10, at 410; FENTIMAN, *supra* note 1, at 647. The socio-economic status and race of women has considerable effects on their pregnancy. *See* MORGAN & ZIMMER, *supra* note 37, at 150. The impact of environment on fetal development was a deciding factor in the final appeal that freed Regina McKnight after eight years in prison. *McKnight*, 661 S.E.2d at 360-61.

socio-economic status, these women are also more likely to become drug addicts.⁵⁹

As recently as January and February of 2013, conflicting cases regarding prosecution of pregnant drug users based on child endangerment statutes made the headlines. On January 11, 2013, in a 6-2 majority holding, the Alabama Supreme Court decided to uphold the application of a child endangerment statute against pregnant drug users.⁶⁰ The pertinent part of the statute provides that “[a] responsible person commits the crime of chemical endangerment of exposing a child to an environment in which he or she . . . [k]nowingly, recklessly, or intentionally causes or permits a child to be exposed to, to ingest or inhale, or to have contact with a controlled substance, chemical substance, or drug paraphernalia.”⁶¹ The statute was originally intended to protect children from parents who turn their homes into methamphetamine labs, but through *Ankrom*, the statute has been expanded to cover pregnant drug users.⁶²

The court held that “the plain meaning of the word ‘child’ in the chemical endangerment statute includes unborn children.”⁶³ The court refused to limit the definition of “child” to viability.⁶⁴ The chemical endangerment statute has been the primary means by which the state of Alabama has convicted women for drug use during pregnancy.⁶⁵ However, some authorities in the state have questioned the use of the statute in this way. Dissenters in the *Ankrom* decision questioned the scope of the law and utilized a slippery slope argument to justify their decision.⁶⁶

Conversely, on February 6, 2013, the New Jersey Supreme Court “unanimously held that the state’s child protection laws do not give

59. FENTIMAN, *supra* note 55, at 236-37.

60. *Ex Parte Ankrom*, 152 So.3d 353 (Ala., 2013).

61. ALA. CODE § 26-15-3.2 (West 2014).

62. Debra Cassens Weiss, *Drug-Abusing Pregnant Women May Be Prosecuted Under Endangerment Law, Ala. Supreme Court Says*, A.B.A. J., Jan. 14, 2013, http://www.abajournal.com/news/article/unborn_children_are_protected_by_chemical_endangerment_law_alabama_supreme/.

63. *Ex Parte Ankrom*, No. 1110176 and 1110219, 2013 WL 135748, at *8 (Ala. Jan. 11, 2013); ALA. CODE § 26-15-3.2 (West 2014); *see* WEISS, *supra* note 62.

64. *Ex Parte Ankrom*, WL 135748 at *8.

65. WEISS, *supra* note 62.

66. *Id.* (noting that dissenting judges questioned whether the statutes would be used to charge a woman for having a glass of wine before she even knows she is pregnant because the court’s interpretation of the statute does not place any limitations on the interpretation of the term “child”).

child protective services jurisdiction over pregnant women and that drug use during pregnancy does not by itself establish abuse or neglect.”⁶⁷ The court recognized amicus brief arguments given by leading medical and public health organizations that acknowledged that “applying child protection laws to pregnant women can be detrimental to the health of the mother and the fetus”⁶⁸ because the possibility of criminal punishment will deter them from seeking proper prenatal care and substance use disorder treatment.⁶⁹ The court based its decision on statutory interpretation, finding that the child endangerment laws apply to “a child less than 18 years of age” and do not extend to an unborn child when the statute refers to a “person” or a “child.”⁷⁰

These cases are in direct opposition with one other. They come to different results through statutory interpretation, and apply contradictory meaning to the term “child.” But the most important takeaway from these cases is the acknowledgement that women should not be prosecuted for their drug use during pregnancy because such prosecution does not fit within the justification for criminal punishment.

B. Criminal Law Theory

Anglo-American jurisprudence primarily relies on four pillars of justification for criminal punishment: deterrence, retribution, incapacitation, and rehabilitation.⁷¹ Today, American justification for punishment typically relies on deterrence and retribution.⁷²

Under the theory of deterrence, “sometimes referred to as *general prevention*, the sufferings of the criminal for the crime he has committed are supposed to deter others from committing future crimes, lest they suffer the same unfortunate fate.”⁷³ In the case of a fetal protection law, knowledge of the law is meant to induce women to stop using drugs prior to and during pregnancy out of fear that they will be incarcerated, involuntarily civilly committed, or have their children taken away.⁷⁴ The laws are intended to induce women

67. SMITH, *supra* note 15.

68. *Id.*; *N.J. Dep’t of Children & Families, Div. of Youth & Family Servs.*, 213 N.J. at 1.

69. *See infra* Section II.C.

70. *Id.*

71. ARTHUR W. CAMPBELL, *LAW OF SENTENCING* § 2:1 (2004).

72. FENTIMAN, *supra* note 55, at 259.

73. WAYNE R. LAFAVE, *1 SUBSTANTIVE CRIMINAL LAW* § 1.5 (2d ed., 2013).

74. *See* LESTER & TWOMEY, *supra* note 5, at 68.

to act in ways that will promote the health and well-being of both mother and fetus:

The theory of simple deterrence is that threats can reduce crime by causing a change of heart, induced by the unpleasantness of the specific consequences threatened. According to this construct, individuals who are tempted to engage in a criminal behavior will refrain from doing so because the pleasure they might obtain from acting thus is more than offset by the risk of great unpleasantness of the criminal sanction that may follow.⁷⁵ Whether or not the deterrence effect is properly seen in response to the fetal protection laws will be the discussed in the following section.

Retribution is the oldest theory of punishment, and the one which “still commands considerable respect from the general public,”⁷⁶ although it only began dominating sentencing theories in the 1980s.⁷⁷ “By this theory . . . punishment is imposed by society on criminals in order to obtain revenge, or perhaps because it is only fitting and just that one who has caused harm to others should himself suffer for it.”⁷⁸

The theory of retribution is seen in the application of the fetal protection laws through the reaction of the public to knowledge of newborns going through withdrawal due to NAS and prosecutorial response to the moral outcry of the public.⁷⁹ While the impact of drug use on the child cannot find consistent footing, public opinion resonates loudly on the issue. The public reacts angrily to reports that babies are born in excruciating pain.⁸⁰ Society does not measure medical impacts in the long-term; it sees harm to an innocent newborn and seeks redress from the individual who caused the harm. However, the theory of retribution is typically criticized as merely a form of retaliation, and is thus morally indefensible.⁸¹

The theory of incapacitation relies on the notion that “society may protect itself from persons deemed dangerous because of their past criminal conduct by isolating these persons from society. If the criminal is imprisoned or executed, he cannot commit further crimes against society.”⁸² This theory is seen through the incarceration of mothers after giving birth to stillborn children, like the case of Regina

75. FRANKLIN ZIMRING, PERSPECTIVES ON DETERRENCE 3 (1971).

76. LAFAVE, *supra* note 73.

77. CAMPBELL, *supra* note 71.

78. LAFAVE, *supra* note 73.

79. See ALECCIA, *supra* note 28; Fentiman, *supra* note 1, at 647.

80. ALECCIA, *supra* note 28.

81. LAFAVE, *supra* note 73.

82. *Id.*

McKnight and other South Carolina cases for homicide and manslaughter based on a mother's use of drugs during pregnancy.⁸³ The theory is to remove the mother from the children whom she could also harm, in addition to preventing another pregnancy.⁸⁴

Under the theory of rehabilitation "we 'punish' the convicted criminal by giving him appropriate treatment, in order to rehabilitate him and return him to society so reformed that he will not desire or need to commit further crimes."⁸⁵ Through rehabilitation, drug users could access treatment for their substance use disorder. There are various approaches to the rehabilitation of pregnant drug addicts including civil commitment in Wisconsin and the alternative sentencing program in California.⁸⁶

C. Prosecution of Pregnant Drug Users Does Not Fit Within the Justifications for Criminal Punishment

Although fetal protection laws appear to utilize the theories of justification for criminal punishment, each law has serious problems in the application of the theories that ultimately causes it to undermine the law's justificatory effectiveness. The biggest issues with criminal justifications occur with the theory of deterrence, which, based on the neurological implications on the addict's brain, do not have the intended effect on individuals suffering from substance use disorders. In fact, deterrence often has the opposite of the intended effect on pregnant women who are substance abusers.

83. *McKnight*, 576 S.E.2d 168. Other women to be charged under similar theories include Jennifer Arrowood, Jamie Lee Burroughs, and Lorraine Patrick. See Nat'l Advocates for Pregnant Women, *South Carolina: Leading the Nation in the Prosecution and Punishment of Pregnant Women* (July 17, 2006), http://advocatesforpregnantwomen.org/issues/punishment_of_pregnant_women/south_carolina_leading_the_nation_in_the_prosecution_punishment.php.

84. See LESTER & TWOMEY, *supra* note 5, at 68.

85. LAFAVE, *supra* note 73.

86. Through civil commitment Wisconsin is able to focus on the treatment of the pregnant woman during the term of her pregnancy. Wisconsin law provides that a pregnant woman may be taken into custody based on a lack of self-control seen through the use of illicit substances and a showing of substantial risk to the unborn child unless the mother is taken into custody. WIS. STAT. ANN. § 48.193 (West 2013). If the expectant mother is believed to be drug dependent, the mother can be detained for up to one year. WIS. STAT. ANN. §§ 51.15 & 51.20 (West 2013). See J. RICHARD COUZENS ET AL., SENTENCING CAL. CRIMES § 7:10, PREGNANT AND PARENTING WOMEN'S ALTERNATIVE SENTENCING PROGRAM ACT (§§ 1174–1174.9) (database updated June 2014).

While theories of deterrence are effective if the wrongdoer recognizes the benefits of not performing the crime over the risks of performing the crime, drug addicts' brains have been altered to not allow such rationalizations.⁸⁷ Neuroscience and behavioral science researchers agree that through repeated use over time, the reward circuitry of the brain is altered to make continued drug use highly reinforcing. In fact, long-term addicts can have cognitive impairments that weaken rationality, diminishing the probability that the threat of a criminal action will be relevant in making decisions about stopping drug use.⁸⁸ Because her sense of logic has been disturbed by a physical need for euphoria, a drug addict is not the "rational man" on whom deterrence has an effect.⁸⁹

In the context of women abusing drugs while pregnant, it is important to recognize that when a women becomes an "addict," her ability to act with self-control can be seriously impaired. "Addiction is a chronic, often relapsing brain disease that causes compulsive drug seeking and use, despite harmful consequences to the addicted individual and to those around . . . her."⁹⁰

Drugs contain chemicals that tap into the brain's communication system and disrupt the way nerve cells normally send, receive, and process information. Drugs cause this disruption by (1) imitating the brain's natural chemical messengers and (2) by causing overstimulation of the "reward circuit" of the brain.⁹¹ "Brain imaging studies from drug-addicted individuals show physical changes in areas of the brain that are critical to judgment, decisionmaking [sic], learning and memory, and behavior control."⁹² This effect on the brain of the drug user makes the justifications for criminalization fall short because the drug user does not have the requisite control over her judgment to deserve criminal punishment.

The goal of deterrence through the fetal protection statutes is to persuade women to protect the health of their fetuses by avoiding drug use and providing proper prenatal care. Some women do in fact

87. See LESTER & TWOMEY, *supra* note 5, at 67.

88. FENTIMAN, *supra* note 55, at 266.

89. *Id.*

90. NAT'L INST. OF HEALTH, NAT'L INST. ON DRUG ABUSE, DRUG FACTS: UNDERSTANDING DRUG ABUSE AND ADDICTION (Nov. 2012), <http://www.drugabuse.gov/publications/drugfacts/understanding-drug-abuse-addiction>.

91. *Id.*

92. NAT'L INST. OF HEALTH, NAT'L INST. ON DRUG ABUSE, DRUGS, BRAINS, AND BEHAVIOR: THE SCIENCE OF ADDICTION 7 (Aug. 2010), <http://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction>.

seek prenatal care, and others try to find drug treatment.⁹³ However, many have found health care professionals to be unsympathetic and judgmental.⁹⁴ This has the potential to lead them to withhold information about their drug use.⁹⁵ Likewise, many pregnant women delay looking for prenatal care or avoid appointments in order to evade being screened for drugs, which they fear could result in being reported to child protective services, losing custody of their children, or subjecting themselves to criminal prosecution.⁹⁶ Fear of judgmental physicians, reporting requirements, and criminal action are the leading reason for the low number of pregnant substance users receiving prenatal care.⁹⁷ In effect, the laws have had the opposite effect of the intended goal—a result known as reverse deterrence. The criminalization of drug use during pregnancy actually deters women from seeking out care that could benefit both themselves and their unborn child because they fear the potential consequences.

The American Congress of Obstetricians and Gynecologists (ACOG) released an opinion stating its commitment to the patients but also to the legal requirements of reporting within the state in which individual practitioners practice.⁹⁸ ACOG advocates treatment for pregnant women suffering from substance use disorders while also recognizing that women are deterred from visiting health care professionals if they are at risk of criminal prosecution.⁹⁹

Courts across the nation have cut down on many of their fetal protection laws through the rulings of appellate courts and legislation based on the recognition of reverse deterrence. In the Florida Supreme Court decision *Johnson v. State*, the court recognized the reverse deterrent effect the laws could have on pregnant mothers leading them to a lack of prenatal care and even seeking out abortion to avoid criminalization.¹⁰⁰ The court in *Johnson v. Florida* cited the decision of *People v. Hardy*,¹⁰¹ a Michigan case, stating:

93. FENTIMAN, *supra* note 55, at 258.

94. *Id.*

95. *Id.*

96. *Id.*

97. LESTER & TWOMEY, *supra* note 5, at 68.

98. AM. COLL. OF OBSTETRICS & GYNECOLOGY, COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist* (Jan. 2011).

99. *Id.*

100. 602 So.2d 1288, 1295-96 (Fla. 1992).

101. 469 N.W.2d 50 (Mich. Ct. App., 1991).

The Michigan court also rejected the prosecutor's argument that charging women with delivery of controlled substances to their newborns provides a strong deterrent against unlawful use of drugs by pregnant women and prompts them to drug treatment. The court noted that prosecution of these women would likely have the opposite effect. A woman may abort her child or avoid prenatal care or treatment out of fear of prosecution. Thus the court concluded that the state's interest was better served by making treatment programs available to pregnant addicts rather than driving them away from treatment by criminal sanctions.¹⁰²

Similarly, Kentucky enacted legislation to put an end to the fetal protection laws that had prevailed in the state. The Maternal Health Act of 1992 prevents the prosecution of a pregnant drug user out of concern that the laws will deter women from seeking out prenatal care.¹⁰³ The Maternal Health Act emphasizes reverse deterrence as a reason for its enactment, stating, "punitive actions taken against pregnant alcohol or substance abusers would create additional problems, including discouraging these individuals from seeking the essential prenatal care and substance abuse treatment necessary to deliver a healthy newborn."¹⁰⁴ Instead of discouraging women from seeking prenatal care and treatment, it is necessary to approach the issue as a public health problem and seek expanded access to prenatal care in addition to education and treatment programs.¹⁰⁵

Additionally, the theory of incapacitation fails to meet the goals of the fetal protection laws. Addiction is caused by a confluence of sources, and experts agree that simply threatening women with jail time cannot solve the problem. "Like many other illnesses, substance abuse is caused by a confluence of genetic, biological, and environmental factors. It can neither be treated nor eliminated simply by punishing as criminals those who suffer from substance abuse."¹⁰⁶

Only the theory of rehabilitation stands up as a justification for criminal punishment, but the theory of rehabilitation has not been used as a primary justification for punishment since the 1970s and 1980s when retribution became the primary theory.¹⁰⁷ Likewise,

102. *Johnson*, 602 So.2d at 1294.

103. SMITH, *supra* note 15.

104. *Cochran v. Commonwealth*, 315 S.W.3d 325, 329 (Ky. 2010).

105. *Id.*

106. FENTIMAN, *supra* note 10, at 410.

107. LAFAVE, *supra* note 73.

criminalization does not typically lead to substance use disorder treatment.

The corrections system has not provided effective substance abuse treatment. Although one-half to two-thirds of the total population in correctional facilities suffers from substance use disorders, only 7 to 17 percent receive treatment while incarcerated.¹⁰⁸ Among the population of pregnant women in prison, the effects of not receiving treatment and quitting cold turkey could cause serious harm to mother and fetus and possibly have fatal effects on the fetus.¹⁰⁹ Though prisons house effective medical centers, they typically do not provide proper, if any, treatment for substance abuse to pregnant women.¹¹⁰ However, adequate treatment is available, and it is now more widely accessible outside of correctional facilities.

Rehabilitation through drug treatment and community support is the most effective means to improving health outcomes for both mother and fetus during pregnancy, but in order to promote drug treatment programs the barriers to health care must be removed. The ACA's essential health benefits (EHBs) have the potential to clear the path necessary to provide pregnant women suffering from substance use disorders access to the treatment that they need in order to have a healthy pregnancy and baby. But, even with the road that the ACA paves for these women, barriers of criminal prosecution, stigma, and fear remain. Without the complete removal of these barriers, substance use disorder treatment is still not attainable.

III. SUBSTANCE USE DISORDER TREATMENT

In order to provide a recommendation for effective treatment that should be provided through the EHBs of the ACA, it is necessary to discuss the current challenges of effective treatment of substance use disorder for pregnant women as well as models of treatment that have proven successful.

The national percentage of pregnant women who entered drug treatment facilities between 2000 and 2010 ranged from 4.4 to 4.8 percent.¹¹¹ However, in 1991 when punitive measures against women

108. *Treating Offenders with Drug Problems: Integrating Public Health and Public Safety*, NAT'L INST. ON DRUG ABUSE, (May 2011), http://www.drugabuse.gov/sites/default/files/drugs_crime.pdf.

109. See Ellen M. Barry, *Pregnant, Addicted and Sentenced: Debunking the Myths of Medical Treatment in Prison*, 5 CRIM. JUST. 23, 23 (Winter 1991).

110. *Id.* at 24.

111. SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ASS'N, THE TEDS REPORT: TRENDS IN SUBSTANCES OF ABUSE AMONG PREGNANT WOMEN AND WOMEN OF CHILDBEARING AGE IN TREATMENT (July 25, 2013),

who used drugs during pregnancy were rising, little was known about addiction treatment for women, and few facilities accepted women, let alone high-risk addicts with immediate need such as pregnant women.¹¹² Indeed, women still struggle to find treatment facilities that give priority to pregnant women, who have an immediate need for treatment, or facilities that provide child care services for pregnant mothers' other children.¹¹³

In addition to the problem of facility access, pregnant women seeking out substance use disorder treatment must consider their available resources. "Lack of resources such as health insurance, transportation and child care, limited residential treatment programs that allow children to stay with their mothers, and staff without training to help the pregnant addict and her children, also dissuade mothers from accessing treatment."¹¹⁴ All of these resources are necessary to provide optimal treatment to pregnant women.¹¹⁵

Researchers have found that the most effective drug abuse interventions work in combination with "prenatal care, child care, human immunodeficiency virus (HIV) counseling, parenting and nutrition classes, and transportation."¹¹⁶ These studies have reported high rates of abstinence from drug use or reduced drug use, retention in treatment, compliance with prenatal care, and good perinatal outcomes.¹¹⁷ With the recent changes in legislation affecting health care, pregnant women with substance use disorders will be able to obtain prenatal care in conjunction with substance use disorder treatment, but only if the barriers to care—that is, the laws causing reverse deterrence—are removed.

<http://www.samhsa.gov/data/spotlight/spot110-trends-pregnant-women-2013.pdf>.

112. Karol L. Kumpfer, *Treatment Programs for Drug Abusing Women*, 1 FUTURE OF CHILDREN 50, 50 (1991).
113. Guttmacher Inst., *State Policies in Brief: Substance Abuse During Pregnancy* (Nov. 1, 2013), http://www.guttmacher.org/statecenter/spibs/spib_SADP.pdf; FENTIMAN, *supra* note 55, at 258-59.
114. LESTER & TWOMEY, *supra* note 5, at 68.
115. *Id.*
116. THOMAS M. BRADY & OLIVIA SILBER ASHLEY, DEPT. HEALTH & HUMAN SERVS., WOMEN IN SUBSTANCE ABUSE TREATMENT: RESULTS FROM THE ALCOHOL AND DRUG SERVICES STUDY (ADSS), (Sept. 2005), <http://www.samhsa.gov/data/WomenTX/WomenTX.htm#2.4.2>.
117. *Id.*

IV. THE AFFORDABLE CARE ACT

Although the criminal justice system has targeted pregnant drug use since the late 1970s, the number of women using illicit drugs remains steady while prescription opiate use during pregnancy is on the rise.¹¹⁸ Substance abuse is an epidemic in the United States. The evidence can be seen in the steady increase in self-identified drug users through the Department of Health and Human Service's annual reports.¹¹⁹ The prevalence of both illicit drug use and legal prescription drug use is increasing thus putting an even greater number of fetuses and newborns at potential risk of long-term health consequences.¹²⁰

As previously detailed, the justifications for criminalization do not stand when applied to fetal protection laws aimed at pregnant drug users.¹²¹ In reality, criminalization has had the opposite of the intended effect.¹²² However, there have been positive results associated with substance use disorder treatment during pregnancy and health care legislation should be used as the access road to provide pregnant women with such treatment.

A. Potential Solution

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (together referred to as the ACA), signed into law in 2010¹²³ by President Barack Obama, proposed a significant solution to the problem of substance abuse during pregnancy. Mandated insurance coverage is required to cover certain essential health benefits (EHBs), including substance abuse treatment. Based on the inclusion of these benefits in health insurance packages, more health care providers can offer and be reimbursed for their services, thus enabling more women access to necessary treatment.¹²⁴

118. *Supra* Section II.A-B.

119. SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ASS'N, *supra* note 20.

120. *See* ALECCIA, *supra* note 28; BEHNKE & SMITH, *supra* note 38, at e1009 (2013); FRESKOS, *supra* note 30.

121. *Supra* Section II.C.

122. *See* FENTIMAN, *supra* note 55, at 269-70.

123. DEP'T OF HEALTH & HUMAN SERVS., *Key Features of the Affordable Care Act*, <http://www.hhs.gov/healthcare/facts/timeline/> (last visited Mar. 18, 2014).

124. Office of Nat'l Drug Control Pol'y, *Substance Abuse and the Affordable Care Act*, THE WHITE HOUSE, <http://www.whitehouse.gov/ondcp/healthcare> (last visited Mar. 18, 2014).

The ACA ensures that “health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, and any state’s Medicaid for new enrollees in 2014” offer a comprehensive package of benefits referred to as EHBs.¹²⁵ Section 1302(b)(1) provides that the EHBs include items and services within ten benefit categories, including maternity and newborn care, and mental health and substance use disorder services, including behavioral health treatment.¹²⁶

1. Essential Health Benefits and Coverage Parity

The inclusion of the mental health and substance use disorders in the list of essential health benefits effectively recognizes that mental health and substance abuse issues are not subordinate to physical health.¹²⁷ Prior to the ACA, attempts had been made to cover mental illness through the Mental Health Parity Act of 1996 (MHPA) and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).¹²⁸ However, it was not

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125. HealthCare.gov, *Essential Health Benefits*, <https://www.healthcare.gov/glossary/essential-health-benefits/> (last visited Mar. 25, 2015). The following combination of provisions under the ACA creates the opportunity for coverage for substance use disorder treatment for pregnant women who may have previously been without coverage for treatment. Section 1201 of the ACA requires insurers offering plans on the individual or small group market to include coverage of the ten EHBs under section 1302. Additionally, section 1301 requires health plans offered on the exchanges to cover the same EHBs. Finally, section 2001 requires Medicaid benchmark plans and benchmark-equivalent plans to provide the same essential benefits health package from section 1302. Patient Protection and Affordable Care Act § 1201; § 1301; § 1302; § 2001; 42 U.S.C. § 18022(b)(1) (2012); Stacey A. Tovino, *All Illnesses Are (Not) Created Equal – Reforming Federal Mental Health Insurance Law*, 49 HARV. J. LEGIS. 1, 41-42 (2012).
126. Patient Protection and Affordable Care Act § 1302(b)(1); 42 U.S.C. § 18022(b)(1); Ctr. for Consumer Info. & Ins. Oversight, *Essential Health Benefits Bulletin*, CMS.GOV, 1-2 (Dec. 16, 2011), http://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.
127. “HHS does not subordinate mental health to physical health in any of its programs, services, or requirements, and appears to have as its goal the promotion of both physical and mental health.” Stacey A. Tovino, *Further Support for Mental Health Parity Law and Mandatory Mental Health and Substance Use Disorder Benefits*, 21 ANNALS HEALTH L. 147, 156 (2012) (arguing for the extension of the federal mental health parity law and mandatory mental health and substance use disorder benefits to all public healthcare program beneficiaries and private health plan members).

until the ACA that coverage for mental illness and substance use disorders was extended to the majority of Americans.¹²⁹

The MHPAEA requires that coverage for substance use disorders be equal to any medical or surgical coverage with respect to financial requirements and treatment limitations.¹³⁰ However, the MHPAEA did not apply to private insurers.¹³¹ Now, in combination with the ACA, mental health and substance abuse parity is required for group health plans and group and individual health insurance coverage because according to section 1302(b)(1), they are required to cover mental health and substance use disorders as essential health benefits.¹³² Insurance companies are still allowed to make coverage limitations as they have always done in the past; however, under the MHPAEA, any insurance that offers mental health and substance use disorder services must have equal coverage limitations for mental health and substance use disorder treatment and any other medical or surgical treatment; therefore, a majority of plans now provide coverage for substance use disorder treatment.¹³³

The ACA, in combination with the MHPAEA, provides an avenue for women who previously did not have insurance coverage for substance use disorders to obtain treatment.¹³⁴ Because the ACA requires coverage of substance use disorder treatment through their inclusion in the EHBs, federal law now mandates that all exchange-offered qualified health plans, non-exchange individual health plans, non-exchange small group health plans, Medicaid benchmark plans, the benchmark equivalent plans, and Medicaid state plans be subject to the parity law.¹³⁵ These women will now no longer face the struggle

128. Tovino, *supra* note 125, at 7-8 (explaining the transition to a higher degree of parity between mental and physical health coverage, Tovino states, “neither the federal Mental Health Parity Act of 1996 (MHPA) nor the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) required private insurers to offer insurance benefits for mental illness”); Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 219,68240 (Nov. 13, 2013) (to be codified in 26 CFR § 54.9812-1; 28 CFR § 2590.712; 45 CFR § 146.136; 45 CFR § 147.136).

129. Tovino, *supra* note 125, at 7.

130. *Id.*

131. *Id.*

132. *Id.*

133. See TOVINO, *supra* note 125.

134. See *supra* Section IV.A.

135. See TOVINO, *supra* note 125.

of a lack of resources such as health insurance coverage necessary to seek out treatment.¹³⁶ However, the specific services to be covered are to be determined by independent state regulation.¹³⁷ This obstacle will be evaluated further in Part V.B.

2. Integration of Care

By removing barriers and allowing women to feel comfortable walking into the doctor's office, physicians can also feel more comfortable in making recommendations for treatment services covered according to the EHB requirements.¹³⁸ But, in order to meet the needs of a very specific population, the facilities available for treatment must have the services best suited for pregnant women.

This problem is partially solved by another requirement of the ACA—electronic health records (EHR). Prior to the ACA's implementation, substance abuse agencies most often had only aggregate data, with few details about a patient's quantity or type of treatment or use of services in the general health system.¹³⁹ But now, all the records including information on detailed services and diagnostic information will be available to the treatment facility.¹⁴⁰ Analyses of these data should not only provide better information on the patients, but should also improve understanding of their general health care.¹⁴¹ With EHR systems constantly updating and sharing information, all health care professionals will have access to the most up-to-date and relevant health information thus enabling physicians to provide optimal care.¹⁴²

A key goal of the ACA is to focus on the overall health of the individual through an integrated health care system that shares information between the various providers a patient sees.¹⁴³ This

136. See LESTER & TWOMEY, *supra* note 5, at 68.

137. Jeffrey A. Buck, *The Looming Expansion and Transformation of Public Substance Abuse Treatment Under the Affordable Care Act*, 30 HEALTH AFF. 1402, 1403 (2011).

138. Tovino, *supra* note 125, at 41-42; see generally AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMM. ON ETHICS, *At-Risk Drinking and Illicit Drug Use: Ethical Issues in Obstetric and Gynecologic Practice*, (Dec. 2008) (recommending that OBGYNs should feel comfortable making "referral[s] to treatment facilities in order to provide patients and their families with medical care that is state-of-the-art, comprehensive and effective.").

139. Buck, *supra* note 137, at 1408.

140. *Id.*

141. *Id.*

142. See *id.*

143. OFFICE OF NAT'L DRUGS CONTROL POL'Y, *supra* note 124.

integrated system will be highly beneficial for the substance use disorder provider, the OBGYN, the mother, and the fetus because the most up-to-date health information from each provider will be taken into account when making medical decisions.

B. Challenges and Recommendations

Although the inclusion of substance use disorders within the ten EHBs and the MHPAEA guarantee of equal coverage for those services, there remain several challenges to providing the optimal solution for pregnant drug users.

Among these challenges is the determination of services that will be defined as benchmarks for the EHB. Originally, the Department of Health and Human Services (HHS) was tasked with responsibility of determining the specific substance abuse services that would be covered.¹⁴⁴ In making this determination, HHS planned to take into account evidence detailing which services allow individuals to get the treatment they require and help them with recovery.¹⁴⁵ However, the allotted time to take testimony on each of the ten EHBs ran out, and HHS declared that each state would independently have the power to determine the level of coverage for the EHBs.¹⁴⁶ By leaving the decisions up to the states, the range of services runs the gamut, and it is uncertain whether the EHB benchmarks will include the services that are most beneficial to pregnant drug users.¹⁴⁷

Additionally, the ACA and MHPEAE do not guarantee the EHBs to every individual with insurance coverage.¹⁴⁸ The EHB's requirement, including the substance use disorder benefits, does not apply in the grandfathered health plan setting, the non-exchange large

144. *Id.*

145. *Id.*

146. Stacey A. Tovino, *A Proposal for Comprehensive and Specific Essential Mental Health and Substance Use Disorder Benefits*, 38 AM. J.L. & MED. 471, 475 (2012).

147. *See supra* Section IV.A. A full description of each state's benchmark plan can be found through the Centers for Medicare & Medicaid Services website. *Additional Information on Proposed State Essential Health Benefits Benchmark Plans*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html> (last visited Apr. 9, 2015).

148. The MHPEAE does not require private insurers to conform to the parity law. Tovino, *supra* note 125, at 7-8; Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; *see* Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 219, 68240 (Nov. 13, 2013) (to be codified in 26 C.F.R. § 54.9812-1; 28 C.F.R. § 2590.712; 45 C.F.R. § 146.136; 45 C.F.R. § 147.136).

group health plan setting, and the self-insured group health plan setting.¹⁴⁹ It is estimated by the federal government that “approximately 133 million Americans obtain health insurance through large employers that have grandfathered group health plans.”¹⁵⁰ However, this number will soon decrease because the plans will not be available for much longer.¹⁵¹ Additionally, Medicare and traditional fee-for-service Medicaid continue to be exempt from the federal mental health parity law, as well as self-funded, non-federal governmental plans whose sponsors have opted out of the federal mental health parity law.¹⁵² This means that even after the full implementation of health care reform, millions of people still will not have the right to the mandatory substance use disorder benefits.¹⁵³

In order to optimally implement the ACA to the greatest benefit of pregnant drug users, the following recommendations should be considered. HHS should revise the tentative determination of covered services under the substance use disorder EHB so that pregnant women can receive treatment that is “coupled with prenatal care, child care, human immunodeficiency virus (HIV) counseling, parenting and nutrition classes, and transportation” because these are the most effective treatment models for pregnant women.¹⁵⁴

Second, the ACA EHBs should be extended to all individuals with health insurance. Insurance laws should be revised to reflect that all insurance providers are required to cover the EHBs listed in Section 1302(b)(1) of the ACA,¹⁵⁵ and the MHPAEA should be revised to apply to all health insurance.

Finally, in order to ensure that the purpose of the criminal law is still supported but without criminal punishment, pregnant women should be placed on a priority list for treatment facilities that provide the aforementioned optimal treatment models. By both removing the criminal punishment, which led to reverse deterrence, and guaranteeing substance use disorder treatment services integrated with prenatal care to pregnant women, the potential harms to the fetus will be greatly reduced.

149. Tovino, *supra* note 125, at 8.

150. *Id.* at 48-49.

151. *Id.*

152. *Id.* at 8.

153. *Id.* at 9.

154. *See* Tovino, *supra* note 146, at 475; BRADY & ASHLEY, *supra* note 116.

155. Patient Protection and Affordable Care Act § 1302(b)(1); 42 U.S.C. § 18022(b)(1).

CONCLUSION

The criminal justice system lacks the proper justification to punish women for their addictions that continue through pregnancy. By criminalizing substance abuse during pregnancy, the system essentially halts the possibility for progress. Women are discouraged from seeking treatment that could prevent harm to their child because they fear prosecution and stigma. The ACA and MHPAEA enable more women to have coverage for substance abuse treatment and open the doors for integrated treatment between the prenatal care team and the substance abuse treatment team.¹⁵⁶ However, without decriminalizing the substance abuse, fear of prosecution will remain and women will not seek the treatment that is now more easily accessible. By removing the barrier of criminal punishment many women see in visiting a physician while addicted to drugs or alcohol, women will have greater access to the care they need.¹⁵⁷

156. See Substance Abuse & Mental Health Servs Admin., *HRSA-NHSC: Behavioral Health Workforce Resources*, http://www.integration.samhsa.gov/HRSA-NHSC_Behavioral_Health_Workforce_Resources.pdf (last visited Apr. 9, 2015) (“Primary and behavioral health care integration is an opportunity under the Affordable Care Act to improve health care quality through the systematic coordination of primary and behavioral healthcare.”).

157. See LESTER & TWOMEY, *supra* note 5, at 68.

