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The Right to Medicaid Payment For Abortion

By PATRICIA A. BUTLER*

The issue of Medicaid funding for abortion is one which has aroused continuing debate, both in state legislatures and in Congress. On one hand are those who oppose use of federal or state funds to secure abortions. They argue that abortion is morally wrong and that providing Medicaid payment for the procedure implicates the government in the taking of human life. On the other hand, proponents of legal abortion point out that antiabortion laws are a relatively recent development. Under the common law, abortions were generally legal; it was not until the early nineteenth century that laws were passed prohibiting the procedure.¹ Thus, supporters of the right to abortion urge that the moral argument is misplaced and that notions of morality change with the times. Women, they insist, have a constitutionally protected right to choose to undergo an abortion; therefore the government cannot restrict the ability of poor women to obtain abortions by refusing to provide them with Medicaid funds. It was hoped that a definitive statement on the issue would be made by the Supreme Court when it agreed to hear three Medicaid abortion cases in its October 1976 term.² The question was later complicated, however, by congressional enactment of an antiabortion amendment to the 1977 appropriations bill for the HEW and Labor departments.³

The Court first stepped into the abortion controversy in 1973 when it decided *Roe v. Wade*⁴ and *Doe v. Bolton*,⁵ the now famous companion cases challenging restrictive state abortion laws. *Roe v. Wade* involved Texas statutes which made it illegal to perform an abortion

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1. See *Roe v. Wade*, 410 U.S. 113, 130-47 (1973).
2. See notes 24-26 & accompanying text *infra*.
3. Act of Sept. 30, 1976, Pub. L. No. 94-439, § 209, 90 Stat. 1434.
4. 410 U.S. 113 (1973).
5. 410 U.S. 179 (1973).

unless it was necessary to save the mother's life. *Doe v. Bolton* challenged Georgia statutes which limited the availability of abortions by requiring that: (1) the attending physician obtain the concurrence of two other physicians that the procedure was necessary; (2) a hospital committee make such a finding; (3) the abortion be performed in an accredited hospital; and (4) the patient be a Georgia resident.

In its opinions in *Wade* and *Bolton*, the Court determined that the decision to abort pregnancy is encompassed in the constitutionally protected right of privacy, as it involves intimate personal rights surrounding family planning and marriage.⁶ Thus, the Court found in *Wade* that the right of a woman to choose abortion in consultation with her physician is one of the "personal rights that can be deemed 'fundamental.'" ⁷ Consequently, a statute infringing upon the right to abortion will be invalidated unless the state can demonstrate a compelling interest in such infringement.⁸ In light of the health risks of the abortion procedure, the Court ruled that the right to choose abortion is not absolute but is qualified according to the stage of pregnancy. With respect to the first trimester of pregnancy, the Court held that, because of the minimal risks abortion poses to the patient's health, the state has no interest whatsoever in regulating the patient-physician decision. The state's interest in the woman's health does arise, however, during the second stage of pregnancy,⁹ at which time the state is justified in imposing some conditions upon abortion services to the extent that such conditions reasonably relate to the preservation and protection of maternal health.¹⁰ The Court held in *Bolton*, however, that conditions such as hospital accreditation and concurrence by hospital review committees or other physicians were invalid since they did not advance maternal health, were not imposed upon performance of other similar procedures, and thus were not supported by a compelling state interest.¹¹

The Court in *Wade* reasoned that only later, at the point of potential fetal viability outside the womb, does the state possess a sufficient interest in the life of the fetus to allow placing restrictions on the performance of abortion.¹² The Court did not expressly designate

6. The Court noted that the privacy right has been extended to activities relating to marriage, procreation, contraception, family relationships, and child rearing and education. 410 U.S. at 152-53.

7. *Id.* at 152.

8. *Id.* at 155.

9. *Id.* at 163.

10. *Id.*

11. 410 U.S. at 198-99.

12. 410 U.S. at 163-64.

the point at which this compelling state interest in fetal life begins. It is generally considered by the medical profession to arise at the commencement of the third trimester of pregnancy, although there is some debate about the actual time after which a fetus can survive alone. Future advances in medical science may make it possible to sustain the fetus outside the womb at an earlier point. Apparently recognizing this potential for technological advances as well as the differing points of viability among fetuses, the Court recently refused to invalidate a state law which defined viability as that stage "when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life-supportive systems."¹³

However imprecise may be the exact time at which the state may legitimately take an interest in fetal life, it is clear that during the first trimester of pregnancy the state cannot impose *any* barriers to abortion when it is chosen by a woman in consultation with her physician. For some period thereafter, the state may not forbid abortions but may regulate the procedure in the interest of preserving and protecting maternal health.

The *Wade* and *Bolton* rulings left several questions unanswered. May a state statute demand spousal or parental consent as a prerequisite to abortion? Must all public hospitals allow their facilities to be used for abortions?¹⁴ Are states obligated to pay for abortions for women

13. *Planned Parenthood v. Danforth*, 96 S. Ct. 2831, 2838 (1976). For purposes of payment for abortions under Medicaid, California has set viability at twenty weeks. California Dep't of Health, Medi-Cal Bull. No. 52A, at 2, Mar. 1976. This administrative action flies in the face of the Supreme Court's express holding in *Danforth* that viability is a medical concept that courts and legislatures may not define. 96 S. Ct. at 2838. See also *Hodgson v. Anderson*, 378 F. Supp. 1008 (D. Minn. 1975). In *Hodgson*, the court invalidated a Minnesota statute prohibiting abortions after twenty weeks. *Id.* at 1016.

The medical literature still supports the Court's contention in *Wade* that viability cannot occur before twenty-four weeks, and probably not until twenty-eight weeks. See, e.g., AMERICAN COLLEGE OF OBSTETRICS AND GYN., *MANUAL OF STANDARDS IN OBSTETRIC-GYNECOLOGIC PRACTICE* 108 (2d ed. 1965); E. WILLIAMS, *OBSTETRICS* 502 (1966). See also expert affidavits submitted in *Hodgson, supra*. It should be noted, however, that viability is defined in Great Britain as twenty weeks. *STEDMAN'S MEDICAL DICTIONARY* 1388 (22d ed. 1972).

14. Cases involving the obligation of municipal hospitals to perform abortions include *Doe v. Poelker*, 497 F.2d 1063 (8th Cir. 1974), *cert. granted*, 96 S. Ct. 3220 (1976) (No. 75-442); *Doe v. Hale Hosp.*, 500 F.2d 144 (1st Cir. 1974); *Doe v. Mundy*, 378 F. Supp. 731 (E.D. Wis. 1974), *aff'd*, 514 F.2d 1179 (7th Cir. 1975); *Nyberg v. City of Virginia*, 361 F. Supp. 932 (D. Minn. 1973); *aff'd*, 495 F.2d 1342 (8th Cir.), *cert. denied*, 419 U.S. 891 (1974). Analogous cases involve the obligation of municipal hospitals to perform sterilization operations. See *Hathaway v. Worcester City Hosp.*,

who cannot afford them?¹⁵

The first of these questions was answered in 1976 in *Planned Parenthood v. Danforth*,¹⁶ where the Court invalidated several challenged provisions of a Missouri abortion statute enacted after *Wade* and *Bolton*. The Court held unconstitutional the state's spousal and parental¹⁷ consent requirements for abortions on the ground that the state cannot "delegate to a [third party] a veto power which the state itself is absolutely and totally prohibited from exercising during the first trimester of pregnancy."¹⁸ The Court also set aside the state's prohibition on the saline amniocentesis abortion method¹⁹ and its requirement that physicians attempt to preserve fetal life.²⁰ Although it failed to define an exact point of fetal viability,²¹ the Court upheld a provision requiring the woman's written consent to abortion²² and mandating that facilities and physicians maintain certain records of abortions performed.²³

More recently, the Court has agreed to hear arguments in three cases raising the remaining abortion issues. *Doe v. Poelker*²⁴ involves the refusal of a city hospital to permit indigents to receive abortions therein. *Roe v. Norton*²⁵ raises the issue of whether the Constitution requires states to provide abortions for women eligible for Medicaid.

475 F.2d 701 (1st Cir. 1973); *McCabe v. Nassau County Medical Center*, 453 F.2d 698 (2d Cir. 1971).

Some courts have held that receipt by private hospitals of federal Hill-Burton Act funds for hospital construction or Medicaid and Medicare funds does not render them "public" institutions required to perform abortions. *Greco v. Orange Memorial Hosp. Corp.*, 513 F.2d 873 (5th Cir.), *cert. denied*, 423 U.S. 1000 (1975); *Chrisman v. Sisters of St. Joseph of Peace*, 506 F.2d 308 (9th Cir. 1974); *Doe v. Bellin Memorial Hosp.*, 479 F.2d 756 (7th Cir. 1973). *Contra*, *Doe v. Charleston Area Medical Center, Inc.* 529 F.2d 638 (4th Cir. 1975). See generally Comment, *Hill-Burton Hospitals After Roe and Doe: Can Federally Funded Hospitals Refuse to Perform Abortions?* 4 N.Y.U. REV. L. & SOC. CHANGE 83 (1974).

15. This argument was briefed to the Court by the National Health Law Program as *amicus curiae*. See Charles & Alexander, *Abortions for Poor and Nonwhite Women: A Denial of Equal Protection?*, 23 HASTINGS L.J. 147 (1971).

16. 96 S. Ct. 2831 (1976).

17. *Id.* at 2840-44.

18. *Id.* at 2841, quoting *Planned Parenthood v. Danforth*, 392 F. Supp. 1362, 1375 (E.D. Mo. 1975).

19. 96 S. Ct. at 2844-45.

20. *Id.* at 2847-48.

21. *Id.* at 2838-39.

22. *Id.* at 2839-40.

23. *Id.* at 2846-47.

24. 515 F.2d 541 (8th Cir. 1975), *cert. granted*, 96 S. Ct. 3220 (1976) (No. 75-442).

25. 408 F. Supp. 660 (D. Conn. 1975), *prob. juris. noted sub nom.* *Maher v. Roe*, 96 S. Ct. 3219 (1976) (No. 75-1440).

*Doe v. Beal*²⁶ challenges a state's failure to pay for abortion as a violation of the Medicaid statute.²⁷

While *Poelker*, *Norton*, and *Beal* were pending in the Supreme Court, Congress complicated resolution of the public funding issue by enacting, over a presidential veto, the "Hyde amendment" to the appropriations bill funding HEW and the Department of Labor for the fiscal year 1977.²⁸ This appropriations "rider," arguably an inappropriate vehicle for substantive policy legislation,²⁹ permits federal payments for abortion only in cases "where the life of the mother would be endangered if the fetus were carried to term."³⁰ That provision is under constitutional attack.³¹ In one of these cases, *McRae v. Mathews*,³² pregnant Medicaid eligibles obtained a preliminary injunction, national in scope and still effective, prohibiting enforcement of the amendment. The District Court for the Eastern District of New York there noted that by withholding federal payment for elective abortions Congress impaired the exercise of the fundamental right of these women to choose abortion as a treatment for their pregnancies.³³

The Supreme Court is now faced with three interrelated but separate questions. *Doe v. Beal*³⁴ raises the issue of whether the Medicaid statute's requirement that all recipients be treated equally mandates states to pay for all abortions under the program, regardless of whether they are elective or "medically required." Since the Hyde amendment

26. 523 F.2d 611 (3d Cir. 1975), *cert. granted*, 96 S. Ct. 3220 (1976) (No. 75-554).

27. 42 U.S.C. §§ 1396-97(f) (1970 & Supp. V, 1975).

28. Act of Sept. 30, 1976, Pub. L. No. 94-439, 90 Stat. 1418.

29. Such a procedure runs counter to Congress' own procedural rules and does not afford the opportunity for committees to investigate and analyze the amendment's impact. 122 CONG. REC. H 8632 (daily ed. Aug. 10, 1976) (remarks of Rep. Abzug).
Abzug).

30. Act of Sept. 30, 1976, Pub. L. No. 94-439, § 209, 90 Stat. 1434. Legislative history indicates congressional willingness to broaden the permissible payments to include rape and incest victims and certain health risks. This evidence would not be relevant to aid in the interpretation of the Hyde amendment since the literal statutory language is clear on its face. *United States v. Shreveport Grain & Elevator Co.*, 287 U.S. 77, 83 (1932); *McDonald v. Best*, 186 F. Supp. 217, 221 (N.D. Cal. 1960); *United States v. Toma*, 148 F. Supp. 489 (C.D. Cal. 1957).

31. *McRae v. Mathews*, 421 F. Supp. 533 (E.D.N.Y. 1976); *Doe v. Mathews*, 420 F. Supp. 865 (D.N.J. 1976); *Doe v. Mathews*, Civil No. 76-1835 (D.D.C., Oct. 21, 1976).

32. *McRae v. Mathews*, 421 F. Supp. 533 (E.D.N.Y. 1976).

33. *Id.* at 542.

34. 523 F.2d 611 (3d Cir. 1975), *cert. granted*, 96 S. Ct. 3220 (1976) (No. 75-554).

was passed as part of an appropriations bill and did not amend the Medicaid law itself, the argument for equality of treatment is still viable. Similarly, *Roe v. Norton*³⁵ questions whether a state's refusal to pay for abortions under Medicaid while it pays for prenatal care and delivery violates the equal protection clause of the fourteenth amendment. The Hyde amendment's restriction of federal payments for Medicaid abortions can be interpreted as not affecting the constitutional obligation of a state to provide equal payment for alternative treatments without federal help, in which case the issues raised in *Norton* are still ripe for review.³⁶

In view of the issues presented by these cases, this article will examine the constitutionality of longstanding state policies restricting Medicaid payment for abortion and of the Hyde amendment itself. In approaching these issues, primary consideration will be given to theories used by litigants attempting to compel Medicaid funding of elective abortions. To provide a context in which these arguments may be understood, the scope of the Medicaid program will be examined briefly, as will the limitations states traditionally have placed on Medicaid payments. First, however, discussion will center on the question whether there is an absolute constitutional right to public funding of voluntary abortions outside the Medicaid program.

Obligations of the States in Funding Abortions for the Poor

Advocates of the right of women to terminate unwanted pregnancies by means of abortion argue that, totally apart from Medicaid, the state is constitutionally mandated to fund the abortions of those unable to afford the operation.³⁷ Proponents of this position argue that by refusing to pay for abortions for poor women while allowing women who can afford the procedure to procure it, the state creates a classification, based solely on wealth, of two groups of women seeking to exercise their right to choose abortion. However, the Supreme Court has thus far refused to term poverty a suspect classification sufficient to trigger

35. 408 F. Supp. 660 (D. Conn. 1975), *prob. juris. noted sub nom.* Maher v. Roe, 96 S. Ct. 3219 (1976) (No. 75-1440).

36. It is possible that the Supreme Court will remand both *Norton* and *Beal* for reconsideration in light of the Hyde amendment, since it has assiduously avoided deciding the Medicaid abortion issue in the past. See, e.g., *Doe v. Westby*, 383 F. Supp. 1143 (D.S.D. 1974), *vacated*, 420 U.S. 968 (1975). That case was remanded by the Supreme Court for consideration of the statutory issue before reaching the constitutional one. See also *Singleton v. Wulff*, 96 S. Ct. 2868 (1976).

37. No court has so far made such a ruling. See Comment, *Abortion on Demand in a Post-Wade Context: Must the State Pay the Bills?*, 41 *FORDHAM L. REV.* 921, 929-31 (1973).

the strict scrutiny equal protection analysis requiring states to advance a compelling interest to justify discriminating between two similarly situated classes of individuals.³⁸ Nor has the Court held that the receipt of welfare benefits³⁹ or health care is a fundamental right which a state may curb only to serve a compelling interest. If unable to establish that a state's refusal to fund abortions for all poor women either creates a suspect classification based on wealth or infringes a fundamental right, a plaintiff can argue only that the policy lacks a rational basis. Yet the Court has said that conserving the public fisc, the obvious rationale, is sufficient to satisfy this test.⁴⁰

Courts *have* compelled states to fund the exercise of certain constitutional rights in other contexts. However, because they have involved access to the judicial or legislative process, the cases obligating states to cover the costs of indigents are probably distinguishable from the case of a poor woman seeking an abortion. For example, in *Griffin v. Illinois*,⁴¹ the Court required the state to provide transcripts or suspend court fees for indigent criminal defendants. That case and others following it⁴² pertained to state created financial barriers to a criminal defendant's access to the courts. Similarly, in *Boddie v. Connecticut*,⁴³ a case specifically abolishing financial obstacles to the poor in civil litigation, the Court held that due process requires states to waive divorce court filing fees for indigents. The Court based its decision on the fact that the state controls the exclusive means of obtaining divorce. Subsequent cases challenging filing fees for indigents in bankruptcy and appellate courts have limited the application of *Boddie* to those fundamental constitutional interests surrounding the family.⁴⁴ The United

38. See *San Antonio School Dist. v. Rodriguez*, 411 U.S. 1, 29 (1973).

39. See *Jefferson v. Hackney*, 406 U.S. 535 (1972); *Dandridge v. Williams*, 397 U.S. 491 (1970).

40. *Jefferson v. Hackney*, 406 U.S. 535, 549 (1972). A state can refuse to offer a service for this reason. However, once it in fact offers such a service, a state cannot use it to interfere impermissibly in the lives of recipients. See *Klein v. Nassau County Medical Center*, 347 F. Supp. 496, 500-01 (E.D.N.Y. 1972), *vacated*, 412 U.S. 925-26 (1973). Cases like *Klein* make it clear that when a state offers medical benefits to pregnant women but refuses them abortions, it is not doing so to save money, since the cost of childbirth is much higher than the cost of abortion. *Doe v. Rose*, 499 F.2d 1112, 1117 (10th Cir. 1974).

41. 351 U.S. 12 (1956).

42. See, e.g., *Anders v. California*, 386 U.S. 738 (1967); *Draper v. Washington*, 372 U.S. 487 (1963); *Lane v. Brown*, 372 U.S. 477 (1963). See also *Harper v. Virginia State Bd. of Elections*, 383 U.S. 663 (1966).

43. 401 U.S. 371 (1971).

44. *Ortwein v. Schwab*, 410 U.S. 656 (1973); *United States v. Kras*, 409 U.S. 434 (1973).

States District Court for the Eastern District of New York in *Klein v. Nassau County Medical Center*⁴⁵ did cite *Boddie* in its opinion holding that the state's limitation of Medicaid payments for abortions violated the equal protection clause of the fourteenth amendment by discriminating between indigent and nonindigent women.⁴⁶ However, since *Klein* preceded those cases narrowing the application of *Boddie*, the court was not called upon to clarify the apparent distinctions between access to the courts and access to health care services.

Because the Supreme Court has elevated the right to choose abortion to the level of a fundamental interest, it might be argued that if the state monopolized the means of obtaining access to abortion, the *Boddie* holding would govern.⁴⁷ Perhaps licensing the physicians and the facilities performing abortions is sufficient "state monopoly" to justify applying this reasoning. However, imposing on states the absolute responsibility to pay a physician to perform an abortion is substantially different from requiring states to waive fees they would otherwise collect, as it creates an affirmative duty to pay a third party to provide a service. Logically extended, this argument would require states to pay for all medical care—or at least that care involving a "basic necessity of life"⁴⁸—for all residents because *some* persons can afford to purchase it from state-licensed providers. Courts have not gone so far under any constitutional doctrine.

Furthermore, in light of recent Supreme Court cases,⁴⁹ there is little likelihood that a state will be constitutionally required to provide free access either to abortion or to other kinds of medical care for its citizens.⁵⁰ None of the plaintiffs in the cases arising after *Wade* and

45. 347 F. Supp. 496 (E.D.N.Y. 1972), *vacated*, 412 U.S. 925-26 (1973), *on remand*, 409 F. Supp. 731 (E.D.N.Y. 1976), *appeal docketed*, 45 U.S.L.W. 3070 (U.S. July 27, 1976) (No. 75-813). See notes 109, 158, & accompanying text *infra*.

46. 347 F. Supp. at 500-01.

47. See *Boddie v. Connecticut*, 401 U.S. 371, 386 (1971) (Douglas, J., concurring). *But see* *Doe v. Wohlgemuth*, 376 F. Supp. 173, 193-95 (W.D. Pa. 1974) (Weis, J., dissenting), *modified sub nom. Doe v. Beal*, 523 F.2d 611 (3d Cir. 1975), *cert. granted*, 96 S. Ct. 3220 (1976) (No. 75-554).

48. *Memorial Hosp. v. Maricopa County*, 415 U.S. 250, 259 (1974) (health care found a basic necessity but not a fundamental right).

49. See, e.g., *United States v. MacCollom*, 96 S. Ct. 2086 (1976); *Geduldig v. Aiello*, 417 U.S. 484 (1974). *But see* *Hagans v. Lavine*, 415 U.S. 528 (1974). The Court has not faced many equal protection cases since *San Antonio School Dist. v. Rodriguez*, 411 U.S. 1 (1973). But recently it has severely limited similar arguments based on the due process clause of the fourteenth amendment. See *Mathews v. Eldridge*, 96 S. Ct. 893 (1976); *Weinberger v. Salfi*, 422 U.S. 749 (1975).

50. See Carey, *A Constitutional Right to Health Care: An Unlikely Development*, 23 CATHOLIC U.L. REV. 492 (1974).

Bolton has attempted to advance such an argument.⁵¹ Fortunately, it has been possible to make far stronger constitutional and statutory arguments in the context of the Medicaid program.

The Federal Medicaid Program

Medicaid, the federal system of medical assistance for the indigent, was enacted in 1965 as Title XIX of the Social Security Act.⁵² Funded jointly by state and federal governments,⁵³ Medicaid is a state-administered program designed to pay the costs of medical care for most welfare recipients and certain other poor individuals.⁵⁴ States are not required to participate in Medicaid, but if they choose to do so,⁵⁵ they must comply with the federal statutes and regulations which outline general program requirements.⁵⁶ Participating states must establish plans detailing the groups of persons covered, the types of services offered, and the minimum conditions which health care providers must meet under the program.

Federal law requires states to provide recipients of federal welfare programs for dependent children⁵⁷ and the aged, blind and disabled⁵⁸—the categorically needy—with at least seven basic benefits: physician services; inpatient hospital services; outpatient hospital services; x-ray and laboratory services; nursing home services; family planning services; and early childhood screening.⁵⁹ Just over half the states under Medi-

51. One court, however, apparently misunderstood plaintiffs' equal protection argument and held that the Constitution did not require Medicaid payment for abortion because the case dealt "with low income status and not with a suspect classification . . . and . . . there is no constitutional right to receive public welfare . . ." *Doe v. Stewart*, No. 74-3197, at n.38 (E.D. La., Jan. 1976), *appeal docketed*, No. 75-6721, 5th Cir., May 26, 1976. Considering this court's misconception of the constitutional argument, its holding should not presage the result of other courts faced with this issue.

52. Act of July 30, 1965, Pub. L. No. 89-97, § 121, 79 Stat. 343 (codified at 42 U.S.C. §§ 1396-96d (1970 & Supp. V, 1975)).

53. The federal government provides between 50% and 83% of the funds, depending on state income. 42 U.S.C. § 1396d(b) (Supp. V, 1975).

54. For a practical overview of the Medicaid system, see Butler, *The Medicaid Program: Current Statutory Requirements and Judicial Interpretations*, 8 CLEARINGHOUSE REV. 7 (1974). For an historical overview, see S. STEVENS & R. STEVENS, *WELFARE MEDICINE IN AMERICA* (1974).

55. All states now participate in the Medicaid program, although Arizona's program is not scheduled to begin until July 1977.

56. *Carleson v. Remillard*, 406 U.S. 598 (1972); *Townsend v. Swank*, 404 U.S. 282 (1971); *King v. Smith*, 392 U.S. 309 (1968).

57. 42 U.S.C. §§ 601-02 (Supp. V, 1975).

58. *Id.* §§ 1381-84. A 1972 Medicaid amendment permitted states to exclude some of those recipients. *Id.* § 1396a(f).

59. *Id.* §§ 1396a(a)(10), (13)(B), 1396d(a)(1)-(5) (1970 & Supp. V, 1975).

caid also cover people who have too much income or too many resources to qualify for welfare, but who are aged, blind, disabled or dependent children within the meaning of the welfare laws. These are the so-called medically needy.⁶⁰ States covering the medically needy must provide either the basic seven services noted above or seven of the sixteen services listed in the Medicaid law, including some institutional and some noninstitutional services, such as drugs, eyeglasses, and dental care.⁶¹ Besides providing seven *required* services, states have the option of offering any additional listed services to both the categorically needy and the medically needy.⁶² Any service offered the medically needy must also be offered to the categorically needy.⁶³ This is the so-called "comparability" requirement.

Medicaid is a vendor payment program designed to reimburse providers of health care for services rendered to program beneficiaries.⁶⁴ It will pay for services if a recipient can locate a provider to treat him or her, but it does not guarantee the availability or accessibility of providers. Because of increasingly burdensome administrative procedures for obtaining payment and because of disparities between fees paid by Medicaid and those paid by private patients, many providers refuse to treat Medicaid patients.⁶⁵ Furthermore, physicians and hospitals participating in the program may choose not to perform abortions. Therefore, it must be remembered that even if restrictive state Medicaid abortion policies are successfully challenged, beneficiaries may still have difficulty finding a provider who will perform the service.

The Medicaid statute prescribes the categories of services which states must cover and specifically permits states to cover many others voluntarily; however, the law does not define the extent of each service, leaving this task largely up to the states.⁶⁶ Thus, states may define the scope of provided services, the duration of provided services (for example, thirty days of hospital care per year), and the amount of services available (for example, ten physician visits per month). The federal statute contains no guidelines regarding the manner in which a state may limit benefits.

60. *Id.* § 1396a(a)(10)(C) (Supp. V, 1975).

61. *Id.* §§ 1396a(a)(13)(C), 1396d(a)(1)-(16) (1970 & Supp. V, 1975).

62. *Id.* § 1396d(a).

63. *Id.* § 1396a(a)(10)(B) (Supp. V, 1975).

64. *Id.* § 1396d(a).

65. See Butler, *The Medicaid Program: Current Statutory Requirements and Judicial Interpretations*, 8 CLEARINGHOUSE REV. 7, 14-15 (1974).

66. See 42 U.S.C. §§ 1396a(a)(10), (14), (17), 1396d(a) (1970 & Supp. V, 1975).

Federal Medicaid regulations are not much more enlightening than the statute in defining the permissible amount or duration of services. One set of regulations defines the maximum amount of services for which the federal government will provide its share of funds⁶⁷ but does not clearly prescribe minimum definitions. Another regulation requires that all covered services "must be sufficient in amount, duration and scope to reasonably achieve their purpose."⁶⁸ With respect to the required services for the welfare recipient group,

the state may not arbitrarily deny or reduce the amount, duration, or scope of, such services to an otherwise eligible individual solely because of the diagnosis, type of illness or condition.⁶⁹

Thus, if a state offers eyeglasses to this group, it cannot limit the services to those with pathological eye conditions only. Eyeglasses do as much, if not more, to improve the vision of those with refractive vision errors as they do to improve the vision of those with eye diseases. Such a limitation runs afoul of the above regulation.⁷⁰

The Medicaid statute does not specifically mention abortion.⁷¹ This is not unusual, since it does not single out any particular medical procedure. Instead, it merely states general service categories such as physician, inpatient, and nursing home services. In this regard, it must be remembered that although the Hyde amendment to the HEW appropriations bill prohibited the use of the federal funds included in that bill for abortion, it did not change the Medicaid statute itself.

Congress amended the Medicaid statute in 1972 to include family planning services,⁷² but it did not call attention to abortion in enacting these amendments.⁷³ In light of public health definitions of family planning and congressional treatment of abortion in other laws prior to adoption of the Hyde amendment, some courts have inferred that when Congress added Medicaid coverage for family planning services without expressly *excluding* abortions, it intended such services to include abortions.⁷⁴ This inference was plausible since Congress specifically exclud-

67. 45 C.F.R. § 249.10(b) (1976).

68. *Id.* § 249.10(a)(5)(i).

69. *Id.*

70. *White v. Beal*, 413 F. Supp. 1141 (E.D. Pa. 1976). See notes 186-88 & accompanying text *infra*.

71. *Doe v. Rose*, 499 F. 2d 1112, 1114 (10th Cir. 1974).

72. Act of Oct. 30, 1972, Pub. L. No. 92-603 § 299E, 86 Stat. 1462, *amending* 42 U.S.C. § 1396d(a) (1970) (codified at 42 U.S.C. § 1396d(a)(4)(C) (Supp. V, 1975)).

73. See S. REP. NO. 92-1230, 92d Cong., 2d Sess. 297 (1972).

74. *E.g.*, *Doe v. Beal*, 523 F.2d 611, 622-23 (3d Cir. 1975), *cert. granted*, 96 S.

ed abortions from family planning services when it enacted other legislation.⁷⁵ Additional evidence for the proposition that the congressional purpose was to include abortion in the family planning services provision of Medicaid was provided by the fact that before 1976 Congress had entertained but had refused to enact two amendments designed, like the Hyde amendment, to prohibit the use of federal Medicaid funds for abortion.⁷⁶

The Hyde amendment was generated in the spring and summer of 1976 when Congress debated a forerunner to the now existing provision.⁷⁷ The House of Representatives passed this original version of the appropriations amendment by a wide margin.⁷⁸ The Senate, however, refused to accept it. As the end of the fiscal year approached, the Senate eventually agreed to accept the amendment, modified to read as follows:

None of the funds contained in this Act shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term.⁷⁹

The conference report on the amendment explained that Congress intended the amendment

to limit the financing of abortions under the Medicaid program to instances where the performance of an abortion is deemed by a physician to be of medical necessity and to prohibit payment for abortions as a method of family planning, or for emotional or social convenience.⁸⁰

The report also expressed a congressional intent to permit abortions in cases of rape or incest and stressed that the amendment was not designed to forbid teaching of or research into abortion procedures by federally funded medical schools.⁸¹ Acknowledging the existence of *Norton, Beal, and Poelker*, the three abortion cases pending before the

Ct. 3220 (1976) (No. 75-554). *But see* cases cited in note 179 *infra*. There is some disagreement among health experts whether abortion is a family planning service, since it is clearly not the best method for regular family planning.

75. 42 U.S.C. § 300a-6 (1970). *See also id.* § 2996f(b)(8) (Supp. V, 1975).

76. H.R. 3153, 93d Cong., 1st Sess. § 198D (1973). The bill became law without this provision restricting use of federal funds for abortion. Act of July 1, 1975, Pub. L. No. 94-48, §§ 1-2, 89 Stat. 247, *amending* 42 U.S.C. § 1396a (1970) (codified at 42 U.S.C. § 1396a(a), (23) (Supp. V, 1975)). The Bartlett amendment to the 1974 HEW appropriations bill would have prohibited using any HEW funds, including Medicaid monies, for abortions. *See* 120 CONG. REC. S 16,832 (daily ed. Sept. 17, 1974).

77. H.R. 14232, 94th Cong., 2d Sess. (1976).

78. 122 CONG. REC. H 6,661 (daily ed. June 24, 1976).

79. Act of Sept. 30, 1976, Pub. L. No. 94-439, § 209, 90 Stat. 1434.

80. H.R. REP. NO. 1555, 94th Cong., 2d Sess. 2 (1976).

81. *Id.*

Supreme Court,⁸² the report noted that "Congress in its action upon this particular appropriations bill [did] not intend to prejudge any constitutional questions involved in those cases."⁸³ Yet, rather than waiting for judicial guidance on the constitutional aspects of the funding issue before legislating on the subject, Congress adopted the Hyde amendment, overrode a presidential veto of the bill,⁸⁴ and thereby complicated the status of the cases before the Court. Some observers fear that the Court will remand both *Beal* and *Norton* for consideration of the effect of the amendment, an action which would serve only to postpone final resolution of the important issues involved.⁸⁵

Should the Court decide, however, to determine the constitutionality of the Hyde amendment, the fate of existing state policies restricting the use of funds under the Medicaid statute may also be decided. The soundness of these state plans is open to question, both because they violate statutory principles of the Medicaid law and because they are subject to constitutional attack. The general outline of these programs is therefore set out in the following section as a backdrop to a discussion of the constitutional and statutory arguments relating to the Medicaid abortion question.

State Limits on Medicaid Payment for Abortion

In response to the *Wade* and *Bolton* decisions, most states have repealed their obviously unconstitutional criminal sanctions against abortions.⁸⁶ Many states, however, have adopted laws which limit access to abortion by requiring parental or spousal consent or by prohibiting Medicaid payment for abortion.⁸⁷ Some state Medicaid agencies have been issued antiabortion regulations without express legislative mandate or authorization.⁸⁸ State policies restricting Medicaid payment for abortion have generally demanded that abortion be "medically indicated"⁸⁹—that is, necessitated by a threat to the mother's life or health⁹⁰

82. See notes 24-36 & accompanying text *supra*.

83. *Id.*

84. 122 CONG. REC. S 17,304, H 11,860 (daily ed. Sept. 30, 1976).

85. See note 36 *supra*.

86. See, e.g., 2 FAMILY PLANNING POPULATION REP. 47-49, 80-81, (1973).

87. See, e.g., 4 *id.* 113 (1975); 3 *id.* 34 (1974); 2 *id.* 47, 145 (1973).

88. See, e.g., S.D. Dep't of Social Servs. R. 28 D.210 (1976).

89. See, e.g., *Doe v. Westby*, 383 F. Supp. 1143, 1145 (D.S.D. 1974), *vacated*, 420 U.S. 968 (1975) (South Dakota regulation); *Roe v. Norton*, 380 F. Supp. 726 (D. Conn. 1974), *rev'd*, 552 F.2d 928 (2d Cir. 1975) (Connecticut regulation); Mo. ANN. STAT. § 208.152(12) (Supp. 1976).

90. See, e.g., *Doe v. Rose*, 499 F.2d 1112, 1113 (10th Cir. 1974) (Utah informal

or by a combination of other factors. These factors may include requirements that the pregnancy result from rape or incest, that physical deformity of the child be apparent, that two additional physicians concur in the decision to abort, or that the procedure be performed only in hospitals accredited by the Joint Commission on Hospital Accreditation. States have also required "prior authorization" for the procedure.⁹¹

Many states have justified such restrictions on the ground that the federal Medicaid law authorizes payment of federal funds only for services which are "medically necessary." They argue that this limitation arises in the preamble to the Medicaid law, which describes the principal objective of Title XIX as payment for "medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services"⁹² They conclude that abortion was not meant to be included in this goal.

These state programs have given rise to concern over widespread discrimination against the poor in obtaining access to abortions. Many litigants have called these restrictive policies into question.

Litigation To Compel Medicaid Payment for Abortion

To date, seventeen suits have been filed challenging restrictive state Medicaid programs,⁹³ and three have been filed challenging the Hyde

policy); *Coe v. Hooker*, 406 F. Supp. 1072, 1078 (D.N.H. 1976) (New Hampshire regulation); *Planned Parenthood Ass'n v. Fitzpatrick*, 401 F. Supp. 554, 578 (E.D. Pa. 1975) (Pennsylvania statute).

91. *See, e.g., Roe v. Norton*, 408 F. Supp. 660, 662 (D. Conn. 1975) (Connecticut regulation).

92. 42 U.S.C. § 1396 (1) (Supp. V, 1975).

93. *Doe v. Beal*, 523 F.2d 611 (3d Cir. 1975), *cert. granted*, 96 S. Ct. 3220 (1976) (No. 75-554); *Roe v. Ferguson*, 515 F.2d 279 (6th Cir. 1975); *Wulff v. Singleton*, 508 F.2d 1211 (8th Cir. 1974), *rev'd*, 96 S. Ct. 2868 (1976); *Doe v. Rose*, 499 F.2d 1112 (10th Cir. 1974); *Klein v. Nassau County Medical Center*, 409 F. Supp. 731 (E.D.N.Y. 1976); *Coe v. Hooker*, 406 F. Supp. 1072 (D.N.H. 1976); *Doe v. Klein*, Civil No. 1-76-134 (D. Idaho, Jan. 1976); *Doe v. Stewart*, No. 74-3197 (E.D. La., Jan. 26, 1976), *appeal docketed*, No. 75-6721, 5th Cir., May 26, 1976; *Doe v. Klein*, Civil No. 76-74 (D.N.J., Feb. 2, 1976); *Roe v. Norton*, 408 F. Supp. 660 (D. Conn. 1975), *prob. juris. noted sub nom. Maher v. Roe*, 96 S. Ct. 3219 (1976) (No. 75-1440); *Doe v. Westby*, 402 F. Supp. 140 (D.S.D. 1975), *appeal docketed*, 45 U.S.L.W. 3070 (U.S. July 27, 1976) (No. 75-813); *Planned Parenthood Ass'n v. Fitzpatrick*, 401 F. Supp. 554 (E.D. Pa. 1975); *Doe v. O'Bannon*, Civil No. 4-74 (D. Minn., Aug. 1, 1975); *Smith v. Tinder*, Civil No. 75-0380CH (S.D.W. Va., Aug. 8, 1975); *Doe v. Myatt*, No. 43-74-48 (D.N.D., Oct. 30, 1975); *Doe v. Bowen*, No. IP74-187C (N.D. Ind. 1974); *Doe v. Rampton*, 366 F. Supp. 189 (D. Utah 1973).

amendment.⁹⁴ Plaintiffs in all but two of these cases⁹⁵ included women eligible for Medicaid who were pregnant at the time they filed suit. Even though several of the pregnant plaintiffs received abortions during the course of the litigation, either through preliminary injunctive orders⁹⁶ or without that guarantee of payment,⁹⁷ they had no difficulty in maintaining their standing to prosecute the cases. The Supreme Court in *Wade* established the standing of a woman, pregnant at the time of filing, whose pregnancy ends before resolution of the case.⁹⁸ Although termination of the pregnancy might appear to moot such a case, the Court found that the situation presented a classic example of an exception to the mootness doctrine: a condition which is "capable of repetition, yet evading review."⁹⁹

In addition to allowing individual plaintiffs to sue, some courts have permitted women's groups to prosecute Medicaid abortion suits.¹⁰⁰ The Supreme Court has recently established the right of physicians alone to bring suit on behalf of their Medicaid patients, on the grounds that restrictive state policies interfere with the physician-patient relationship and that the physician is a competent representative of the patient's interest.¹⁰¹

Constitutional Implications of States' Refusal To Fund Abortions

The constitutional arguments in favor of requiring states to fund abortions under Medicaid are very strong and persuasive. This is true even in light of the Hyde amendment, since that provision limits payment of federal funds but arguably does not directly affect state action.

94. *McRae v. Mathews*, 421 F. Supp. 533 (E.D.N.Y. 1976); *Doe v. Mathews*, 420 F. Supp. 865 (D.N.J. 1976); *Doe v. Mathews*, Civil No. 76-1835 (D.D.C. Oct. 21, 1976).

95. *Wulff v. Singleton*, 508 F.2d 1211 (8th Cir. 1974), *rev'd*, 96 S. Ct. 2868 (1976); *Planned Parenthood Ass'n v. Fitzpatrick*, 401 F. Supp. 554 (E.D. Pa. 1975).

96. *Doe v. Beal*, 523 F.2d 611 (3d Cir. 1975); *McRae v. Mathews*, 421 F. Supp. 533 (E.D.N.Y. 1976); *Doe v. Mathews*, Civil No. 76-1835 (D.D.C., Oct. 1, 1976); *Doe v. Klein*, Civil No. 76-74 (D.N.J., Feb. 2, 1976); *Doe v. Stewart*, No. 74-3197 (E.D. La., Jan. 26, 1976); *Roe v. Norton*, 380 F. Supp. at 728 (D. Conn. 1974), *rev'd*, 552 F.2d 928 (2d Cir. 1975).

97. *Doe v. Westby*, 402 F. Supp. 140 (D.S.D. 1975) (3-judge ct.), *appeal docketed*, 45 U.S.L.W. 3070 (U.S. July 27, 1976) (No. 75-813).

98. *Roe v. Wade*, 410 U.S. 113, 124-25 (1973).

99. *Id.*, quoting *Southern Pacific Terminal Co. v. ICC*, 219 U.S. 498, 515 (1911); see *Doe v. Poelker*, 497 F.2d 1063, 1067 (8th Cir. 1973), *prob. juris. noted*, 96 S. Ct. 3220 (1976) (No. 75-442); *Doe v. O'Bannon*, Civil No. 4-74 (D. Minn., Aug. 1, 1975).

100. See, e.g., *Roe v. Ferguson*, 389 F. Supp. 387 (S.D. Ohio 1974), *rev'd*, 515 F.2d 279 (6th Cir. 1975).

101. *Singleton v. Wulff*, 96 S. Ct. 2868, 2873-76 (1976).

Equal Protection of the Laws

The equal protection clause of the fourteenth amendment prohibits a state from discriminating between two similarly situated groups of people unless the state can defend the disparate treatment. The Supreme Court has developed two tests for equal protection. If the state's action infringes upon a fundamental constitutional right or involves a suspect classification such as race, the state must advance a compelling interest to justify its discrimination. Where there is neither a suspect classification nor a fundamental right—for example, in the case of welfare benefits—the discrimination will be upheld if it is rationally related to a legitimate state policy.

In establishing restrictive state Medicaid abortion policies, states have classified similarly situated women eligible for Medicaid in at least three different ways: (1) pregnant women who require abortions to protect life or health as against those who wish abortions but do not need them to preserve life or health; (2) pregnant women who seek to carry their pregnancies to term as against those who seek abortion; and (3) women seeking various types of surgery as against those seeking abortion. In addition, it is possible to analyze the state restrictions on Medicaid abortions as discriminating between nonindigent women, whose access to abortions was unimpeded, and indigent women dependent upon Medicaid whose access to abortions was severely curtailed. Because the right to choose abortion in the first trimester is a fundamental adjunct to the right of privacy and in the second trimester is a right qualified only by the state's interest in protecting the mother, the state must advance a compelling interest for such discrimination.¹⁰² Courts have held that states have been unable to rationalize their antiabortion policies under either the compelling interest test or the less stringent rational basis test.

Discrimination Among Women Seeking Abortion

The state Medicaid abortion policies discussed above discriminate between two groups of Medicaid eligibles who seek abortion: women requiring the procedure to protect life or health and women seeking it for reasons which might not be characterized as medical. In *Doe v. Rose*,¹⁰³ the United States District Court in Utah analyzed by means of this classification the state's policy of paying only for those abortions

102. See notes 38-40 & accompanying text *supra*.

103. 380 F. Supp. 779 (D. Utah 1973), *aff'd*, 499 F.2d 1112 (10th Cir. 1974).

necessary to save the mother's life or to prevent serious and permanent impairment of her physical health. In its conclusions of law, the court invalidated the policy as an impermissible discrimination between women seeking therapeutic abortions and those seeking nontherapeutic ones.¹⁰⁴ Without defining the precise classes involved in the discrimination, the United States Court of Appeals for the Tenth Circuit affirmed,¹⁰⁵ holding that the state must advance a legitimate and compelling interest to warrant such discrimination. The court found that saving the public fisc is not a sufficiently compelling interest, because fundamental rights were involved.¹⁰⁶ Indeed, concern for saving public funds was held to be insufficient even under the rational basis test, since abortion is less costly than prenatal care and subsequent delivery.¹⁰⁷ The court further held that the state may not justify its policy on moral grounds.¹⁰⁸

Discrimination Among Pregnant Women

Many courts have characterized state abortion classifications as discriminating between pregnant women who wish to terminate their pregnancies by delivery and pregnant women who wish to terminate their pregnancies by abortion. Actually, since all states pay for at least those abortions under Medicaid which are required to save the mother's life, this representation is not quite accurate, but it appears to have the greatest appeal to the courts.

In the first Medicaid abortion case, *Klein v. Nassau County Medical Center*,¹⁰⁹ a federal district court in New York found that the state's policy of paying for abortions only when necessary to preserve the health of the mother created two classes of pregnant medicaid eligibles—those who choose to bear the child and those who choose to abort.¹¹⁰ State action as to both these classifications was found to be unconstitutional. A finding of unconstitutionality, however, was not based on the "strict scrutiny" test. A year before *Wade* and *Bolton*, the court was willing to

104. *Id.* at 781-82.

105. 499 F.2d 1112 (10th Cir. 1974).

106. *Id.* at 1117.

107. *Id.*, quoting *Klein v. Nassau County Medical Center*, 347 F. Supp. 496, 500-01 (E.D.N.Y. 1972), *vacated*, 412 U.S. 925 (1973).

108. 499 F.2d at 1117.

109. 347 F. Supp. 496 (E.D.N.Y. 1972), *vacated*, 412 U.S. 925 (1973). The Supreme Court vacated and remanded the case for reconsideration in light of the *Wade* and *Bolton* cases.

110. "The pregnant woman may not be denied necessary medical assistance because she has made an unwarrantedly disfavored choice. . . ." 347 F. Supp. at 500.

do no more than suggest that there "may well be" a fundamental right to choose abortion.¹¹¹ Rather, the classifications fell under the rational basis test, as the court found no supportable reason for the state to discriminate against indigent women seeking elective abortion.¹¹²

Following the *Klein* reasoning, the federal district court in *Doe v. Wohlgemuth*¹¹³ found that Pennsylvania's restrictions on elective abortions,¹¹⁴ like New York's, unconstitutionally discriminated "between indigent women who choose to carry their pregnancies to birth, and indigent women who choose to terminate their pregnancies by abortion."¹¹⁵ In light of *Wade* and *Bolton*, the *Wohlgemuth* court applied the strict scrutiny test¹¹⁶ to determine that the state's reasons for invading the plaintiffs' constitutional rights to privacy were not sufficiently compelling.¹¹⁷

The court did restrict its holding to the first trimester of pregnancy,¹¹⁸ but did not clearly explain this limitation. In affirming the lower court's decision on statutory grounds, the Third Circuit in *Doe v. Beal*¹¹⁹

111. *Id.*

112. The court ruled that "[n]o interest of the State is served by the arbitrary discrimination. . . ." *Id.* Saving public funds was rejected as a rationale since alternative care for pregnancy was more expensive than abortion. Also, since New York had repealed its antiabortion laws, the state was held to have no interest in discouraging abortions. If such an interest existed, the court ruled that the state could not single out indigent women as the sole class against whom this interest could be enforced. 347 F. Supp. at 500-01, *citing* *Boddie v. Connecticut*, 401 U.S. 371 (1971).

113. 376 F. Supp. 173 (W.D. Pa. 1974), *modified sub nom.* *Doe v. Beal*, 523 F.2d 611 (3d Cir. 1975), *cert. granted*, 96 S. Ct. 3220 (1976) (No. 75-554).

114. The challenged restrictions were regulations of the Pennsylvania Department of Public Welfare. They required that two physicians concur in writing that the abortion is necessary and they provided that abortions were compensable only in the following situations: (1) the health of the mother was threatened; (2) the fetus showed evidence of physical deformity or mental deficiency; or (3) the pregnancy resulted from rape or incest and the pregnancy was a threat to the mother's health.

115. *Id.* at 191.

116. *Id.* at 189.

117. The state presented two rationales for its regulations. First, it claimed an interest in saving public funds by withholding reimbursement for elective abortions. This was rejected as irrational in light of higher costs for other treatment for pregnancy. *Id.* at 187. In addition, "fiscal integrity" was held to be insufficient in general as a justification for invading the constitutional right to privacy. *Id.* at 188. Second, the state claimed that its regulations were rational because they were drawn up by a panel of doctors concerned about the conditions under which abortions were performed. This argument was rejected on the basis of language in *Roe v. Wade* which made clear that the state cannot interfere in consultations between doctor and patient in the first trimester of pregnancy. 376 F. Supp. at 189, *quoting* *Roe v. Wade*, 410 U.S. 113, 163 (1973).

118. 376 F. Supp. at 190.

119. *Doe v. Beal*, 523 F.2d 611 (3d Cir. 1975), *cert. granted*, 96 S. Ct. 3220 (1976) (No. 75-554).

specifically directed the court to modify its order and invalidate Pennsylvania's restrictions in the first *and second* trimesters because "the decisions of the Supreme Court have forced the states to include elective abortion in the legal practice of medicine through the second trimester of pregnancy" ¹²⁰

Several other courts have since adopted the approach of *Wohlge-muth* and *Klein* in analyzing discriminatory systems and in holding that neither state fiscal policies nor moral concerns can justify restrictions on use of Medicaid funds for abortion.¹²¹ States have not been able to advance reasons justifying restrictive policies under either the strict scrutiny or rational basis tests. Fiscal justifications have been roundly rejected, as abortion is far less costly than a course of prenatal care followed by delivery.¹²² The cost of supporting the child on welfare after it is born is also considerable.¹²³ Furthermore, early abortion is medically safer than childbirth,¹²⁴ so that states cannot rationally claim to be protecting maternal health by refusing to provide Medicaid funds for abortion.

Discrimination Between Abortion and Other Surgery

No court has explicitly defined the classes created by restrictive Medicaid abortion plans in terms of pregnant women seeking abortion

120. *Id.* at 622, *citing* *Roe v. Wade*, 410 U.S. 113, 164 (1973). The court did suggest that the state could require that second trimester abortions be performed in a manner which would safeguard the mother's health—that is, in a hospital. *Id.* n.25.

121. *Wulff v. Singleton*, 508 F.2d 1211 (8th Cir. 1974), *rev'd*, 96 S. Ct. 2868 (1976); *Roe v. Norton*, 408 F. Supp. 660, 665 (D. Conn. 1975); *Doe v. Westby*, 402 F. Supp. 140 (D.S.D. 1975) (3-judge ct.), *appeal docketed*, 45 U.S.L.W. 3070 (U.S. July 27, 1976) (No. 75-813); *Planned Parenthood Ass'n v. Fitzpatrick*, 401 F. Supp. 554, 581 (E.D. Pa. 1975); *Doe v. Myatt*, No. 43-74-48 (D.N.D. Oct. 30, 1975). One court has held that a state's restrictive Medicaid abortion policy violated the equal protection clause of the fourteenth amendment. It did not clearly define the classes created. *Doe v. O'Bannon*, Civil No. 4-74, at 69 (D. Minn., Aug. 1, 1975).

122. On the average, first trimester abortions under Medicaid cost \$150, and second trimester abortions cost \$350. *See generally* HEW Memorandum, *Effects of General Provision 413 of the Labor-HEW Act*, 120 CONG. REC. 19678 (daily ed. Nov. 20, 1974). The average cost of childbirth under Medicaid ranges from five hundred to eight hundred dollars. *Jaffee, Short-Term Costs and Benefits of United States Family Planning Programs*, 5 STUDIES IN FAMILY PLANNING 101 (1974).

123. The cost of the child's first year in public assistance is at least \$2,000. Memorandum on effects of section 209 from Deputy Ass't Secretary for Population Affairs, Dep't of Health, Educ. & Welfare to House-Senate Conference Committee on Labor-HEW Appropriations Bill, June 25, 1976.

124. *Roe v. Wade*, 410 U.S. 113, 149 (1973).

and women, whether pregnant or not, requesting other surgical procedures of similar medical complexity and risk. However, one court examining state restrictions on other procedures involving the same constitutional right to privacy has analyzed the problem in these terms.

In *Hathaway v. Worcester City Hospital*,¹²⁵ the plaintiff, who would have been endangered from further pregnancy, sought and was refused surgical sterilization from the local municipal hospital. Bringing suit in federal court, she claimed that the hospital's policy against performing sterilization operations violated her rights under the equal protection clause. The First Circuit agreed. The hospital's board of directors, the court said, had broad discretion to allow or disallow surgical procedures. Sterilization was disallowed, but nontherapeutic surgery of comparable medical risk and complexity was permitted. The court stated:

[T]he hospital is not required to perform all kinds of nontherapeutic or even all therapeutic surgical procedures. [But] once the state has undertaken to provide general short term hospital care, as here, it may not constitutionally draw the line at medically indistinguishable surgical procedures that impinge on fundamental rights.¹²⁶

Looking to the *Wade* and *Bolton* decisions, the court concluded that a fundamental right had in fact been infringed:

While *Roe* and *Doe* dealt with a woman's decision whether or not to terminate a particular pregnancy, a decision to terminate the possibility of any future pregnancy would seem to embrace all of the factors deemed important by the Court in *Roe* in finding a fundamental interest, but in magnified form, particularly . . . given the demonstrated danger to appellant's life . . .¹²⁷

Since *Hathaway* equates sterilization with abortion procedures, the case is valid precedent for the principle that a state offering nontherapeutic surgical procedures to a similarly situated class of persons cannot withhold abortions from members of that same class. Considering the success of other equal protection approaches, this characterization of the classifications arising from restrictive abortion policies is not of critical importance, but it does appear to be viable, although the Supreme Court's most recent abortion opinions suggest that states may impose

125. 475 F.2d 701 (1st Cir. 1973).

126. *Id.* at 706.

127. *Id.* at 705 (emphasis added & citations omitted). The court also noted that the state's interest in preserving the life of future fetuses was even less compelling than the state's interest in preserving *existing* fetuses, which *Roe v. Wade* held insufficiently compelling during the first trimester of pregnancy.

some requirements on abortion which they do not impose on other surgery.¹²⁸

Discrimination Between Nonindigent and Indigent Women

Two cases have found illegal discrimination between the class of nonindigent women who, because they are dependent upon their statutory entitlement to state supported Medicaid, are being denied access to elective abortions.

The first of these cases is *Klein v. Nassau County Medical Center*,¹²⁹ which also found discrimination between Medicaid recipients choosing to bear children and Medicaid recipients choosing to abort. The court also found the discrimination based on wealth to be of concern:

The directive, and the State statute, if interpreted as mandating the Commissioner's directive, would deny indigent women the equal protection of the laws to which they are constitutionally entitled. They alone are subjected to State coercion to bear children which they do not wish to bear, and no other women similarly situated are so coerced. Other women, able to afford the medical cost of either a justifiable abortifacient act or full term child birth, have complete freedom to make the choice in the light of the manifold of considerations directly relevant to the problem uninhibited by any State action. The indigent is advised by the State that the State will deny her medical assistance unless she resigns her freedom of choice and bears the child. She is denied the medical assistance that is in general her statutory entitlement, and that is otherwise extended to her even with respect to her pregnancy.¹³⁰

The court found that the state had no legitimate interest to justify such a discrimination.¹³¹

Klein, it will be remembered, is a decision predating *Wade* and *Bolton*, and it therefore turned on the rational basis test. The later case

128. See *Planned Parenthood v. Danforth*, 96 S. Ct. 2831, 2840 (1976) (upholding prior authorization for abortion although it was not required for other surgery); *Bellotti v. Baird*, 96 S. Ct. 2857 (1976). But see *Roe v. Norton*, 408 F. Supp. 660, 665 (D. Conn. (1975), *prob. juris. noted sub nom. Maher v. Roe*, 96 S. Ct. 3219 (1976) (No. 75-1440). In *Norton*, the court specifically invalidated the state's requirement of prior authorization for first trimester abortions because they create "the sort of delay that the Supreme Court found constitutionally repugnant in *Doe v. Bolton*." 408 F. Supp. at 665. Prior authorization is a review method used by many states to control unnecessary services. Kelmer, *Promptness in the Delivery of Service Under Medicaid: The Misuse of Prior Authorization Procedures*, 9 CLEARINGHOUSE REV. 242 (1975).

129. 347 F. Supp. 496 (E.D.N.Y. 1972), *vacated*, 412 U.S. 925 (1973).

130. *Id.* at 500.

131. *Id.* at 500-01.

of *McRae v. Mathews*¹³² disapproved of such a classification under the compelling interest test. *McRae* is not a case dealing with state restrictions on Medicaid. Rather, it is the case holding the Hyde amendment unconstitutional, and the injunction resulting from the case is still operating to suspend the effect of that amendment. Nevertheless, *McRae* is good authority as to the constitutional limits of state action, since the federal government can no more deprive persons of equal protection than can state governments.¹³³

The *McRae* court noted that the Hyde amendment did not affect nonindigent women but that "the needy, the wards of government, would by this enactment, be denied the means to exercise their constitutional right."¹³⁴ Finding that the only reason for denial¹³⁵ of medical assistance by the federal government was "because the woman has chosen to exercise a constitutionally protected right,"¹³⁶ the court enjoined the secretary of HEW from paying heed to the Hyde amendment.

The classification between rich and poor in these cases resulted from the fact that the government has chosen to subsidize medical care only for poor people. Once having decided to supply medical care to this class of people, the government cannot deny women in this class their constitutional right to choose whether to bear children, absent a compelling reason for doing so.

Due Process of Law: Unconstitutional Conditions

The "unconstitutional conditions" doctrine, deriving primarily from the fourteenth amendment's due process clause, prohibits states from conditioning the receipt of statutory entitlements upon the forfeiture of fundamental constitutional rights. This theory was well established in a line of cases dating from *Sherbert v. Verner*,¹³⁷ wherein the Supreme Court invalidated a state's refusal to provide unemployment benefits to a woman whose religious beliefs forbade her to work on Saturday. The Court there held that conditioning receipt of unemployment compensation on the beneficiary's agreement to work on Saturday would require her to forfeit her first amendment right to free exercise of religion and was therefore unconstitutional.¹³⁸

132. 421 F. Supp. 533 (E.D.N.Y. 1976).

133. *Bolling v. Sharpe*, 347 U.S. 497 (1954).

134. 421 F. Supp. at 542.

135. As to whether medical assistance would in fact be denied see text accompanying notes 214-33 *infra*.

136. 421 F. Supp. at 542.

137. 374 U.S. 398 (1963).

138. See also *Perry v. Sinderman*, 408 U.S. 593 (1972); *Keyishian v. Board of*

The unconstitutional conditions doctrine, however, is easily articulated in equal protection terms, as is illustrated by two recent Supreme Court cases. In both *Shapiro v. Thompson*¹³⁹ and *Memorial Hospital v. Maricopa County*,¹⁴⁰ the Supreme Court considered the constitutionality of conditioning the receipt of welfare and indigent medical benefits upon a lengthy period of residency. The court held in both instances that states or counties could not withhold statutory benefits because indigents had recently exercised their constitutional right to travel. Both decisions did not mention the due process clause but purported to turn on equal protection principles—illegal classifications discriminating against indigents who had exercised a fundamental right.

None of the Medicaid abortion cases has used the *Sherbert* due process reasoning. All the cases have found equal protection analysis more convenient. The following language, however, from *Roe v. Norton*,¹⁴¹ an equal protection argument, illustrates the potential for a due process argument:

[W]hen Connecticut refuses to fund elective abortions while funding therapeutic abortions and prenatal and postnatal care, it weighs the choice of the pregnant mother against choosing to exercise her constitutionally protected right to an elective abortion. Her choice is affected not simply by the absence of payment for the abortion, but by the availability of public funds for childbirth if she chooses not to have the abortion. When the state thus infringes upon a fundamental interest, it must assert a compelling state interest that justifies the incursion.¹⁴²

As due process analysis adds nothing that cannot be achieved under the equal protection clause, there is no need to dwell on it. However, it is worth noting that the unconstitutional conditions doctrine is yet another way in which restrictive Medicaid policies on abortion fail to meet minimal constitutional standards.

The Meaning of "Medically Necessary" in the Abortion Context

In grasping for a rationale to vindicate restrictions on Medicaid payment for abortion to cases where the procedure is necessary to

Regents, 385 U.S. 589 (1967); *Slochower v. Board of Educ.*, 350 U.S. 551 (1956); *United States v. Chicago, Milwaukee, St. P. & Pac. R.R.*, 282 U.S. 311 (1931); *Frost Trucking Co. v. Railroad Comm'n*, 271 U.S. 583 (1926); Comment, *Another Look at Unconstitutional Conditions*, 117 U. PA. L. REV. 144 (1968).

139. 394 U.S. 618 (1969).

140. 415 U.S. 250 (1974).

141. 408 F. Supp. 660 (D. Conn. 1975), *prob. juris. noted sub nom.* *Maher v. Roe*, 96 S. Ct. 3219 (1976) (No. 75-1440).

142. *Id.* at 663-64.

preserve maternal health or life, some states have relied on two sections of the Medicaid law. One of these is section 1396a(a)(17), which permits a state to "include reasonable standards . . . for determining eligibility for and the extent of medical assistance . . . consistent with the objectives of [Title XIX]."¹⁴³ The other section is the preamble to the act, which arguably describes the act's objectives and requires states to pay for medical assistance to those whose "income and resources are insufficient to meet the costs of necessary medical services."¹⁴⁴ States wishing to restrict Medicaid payments claim that abortions not necessary to protect life or health fail to meet this standard. This argument raises philosophical and legal questions about the meaning of the term "medically necessary."

As noted, states have generally defined "medically necessary" to mean necessary to save life or prevent permanent impairment to health, even though the Supreme Court specifically rejected such a definition in *Doe v. Bolton*.¹⁴⁵ The term may have several meanings—that intended by Congress, that referred to in the medical community, or that required by constitutional analysis. As courts have intermingled these different definitions while giving great significance to the medical necessity issue, it is important to analyze the term quite specifically. Because of *Wade* and *Bolton*, the term "medically necessary" does not permit states to deny payment for abortion. Medical necessity is a red herring issue that states have raised to camouflage their philosophical opposition to funding the procedure.

Congressional intent in drafting the preamble to the Medicaid statute is so ambiguous as to be meaningless¹⁴⁶ and does not advance

143. 42 U.S.C. § 1396a(a)(17) (Supp. V, 1975).

144. *Id.* § 1396. One court has held that the preamble, not other parts of the law, sets forth the objectives of the act. *California Welfare Rights Org. v. Richardson*, 348 F. Supp. 491, 496 (N.D. Cal. 1972).

145. 410 U.S. 179, 186, 191-92 (1973). See note 152 *infra*.

146. Congress did not explain what it meant by "medically necessary" as used in the Medicaid statute's preamble. The placement of the words renders them ambiguous at best. The preamble requires states to pay for medical care for *persons* who have insufficient income and resources "to meet the costs of necessary medical services . . ." 42 U.S.C. § 1396 (Supp. V, 1975). The term thus appears to modify only a person's eligibility for Medicaid, not the types of medical assistance that states may provide under program. In 1974 the United States District Court in Connecticut adopted this interpretation of the preamble. *Roe v. Norton*, 380 F. Supp. 726, 728 (D. Conn. 1974), *rev'd*, 552 F.2d 928 (2d Cir. 1975).

Regardless of whether Congress intended in 1965 to exclude Medicaid payment for unnecessary medical care, it amended the statute in 1967 to include an express requirement that states implement systems to control the use of "unnecessary" services. Act of Jan. 2, 1968, Pub. L. No. 90-248, § 237, 81 Stat. 911 (codified at 42 U.S.C. §

analysis of the term. A more useful definition of "medically necessary" care is that used in the medical community: the care which is responsive to the problem for which it is offered.¹⁴⁷ To apply this interpretation to any procedure requires first that one identify the condition for which care is offered and second that one determine whether the proffered treatment is safe and efficacious for that condition.¹⁴⁸ If the diagnosis is cancer, for example, treatment is clearly called for, and the treatment offered must be one that is accepted by a significant part of the medical community as effective and safe. With respect to abortion, the diagnosis is pregnancy which is recognized as requiring medical treatment, although it is not considered a disease or pathology.¹⁴⁹ Once

1396a(a)(30) (1970 & Supp. V, 1975)). Congress did not define the term "unnecessary," but it at least made clear that it intended to prohibit payment for unnecessary medical services.

Since there is no evidence that Congress mandated a national definition, it is likely that it expected states to develop standards for determining medical necessity on some rational basis, probably in conjunction with the medical profession.

The professional standards review organization law, 42 U.S.C. §§ 1320c-1 to -19 (Supp. V, 1975), delegates to local groups of physicians the function of setting standards of medical necessity and applying them to Medicaid patients. Beginning with inpatient hospital procedures in 1977, they will eventually review outpatient services as well. Certainly, the Medicaid statute gives wide latitude to states to design and administer their programs. See *Doe v. Beal*, 523 F.2d 611, 616 (3d Cir., 1975), *cert. granted*, 96 S. Ct. 3220 (1976) (No. 75-554). It is possible that Congress intended to permit states to determine whether a given treatment is safe and efficacious as well as the types of medical conditions that they will cover. One court has interpreted section 1396a(a)(10) (A) to permit states to determine the conditions which Medicaid will cover and to require them to pay for all appropriate medical alternatives a physician might choose to treat each condition. *Doe v. Beal*, *supra* at 620-21. Because in *Beal* the state obviously had chosen to cover pregnancy, the court did not have to determine what standards a state could use in choosing whether to cover a particular condition. This is a loophole in permitting state discretion. This analysis would allow the states to limit the services for which they will pay. As will be seen, however, *Wade* and *Bolton* prohibit such state restrictions on the choice of treatment for family planning or pregnancy.

147. See Bunker, *Elective Hysterectomy: Pro and Con*, 295 N. ENG. J. MEDICINE 267 (1976); cf. STAFF OF HOUSE SUBCOMM. ON OVERSIGHT AND INVESTIGATION OF THE COMM. ON INTERSTATE AND FOREIGN COMMERCE, 94TH CONG., 2D SESS., COST & QUALITY OF HEALTH CARE: UNNECESSARY SURGERY 9 (1976) [hereinafter cited as UNNECESSARY SURGERY]; *Klein v. Nassau County Medical Center*, 347 F. Supp. 496 (E.D.N.Y. 1972), *vacated*, 412 U.S. 925-26 (1973). See also 42 U.S.C. § 1396a(a)(30) (Supp. V, 1975); 45 C.F.R. §§ 250.18-19 (1976).

148. Obviously, the difficulty with this definition is in the second step: deciding by what standard a treatment alternative is determined to be safe and efficacious. Cancer treatment presents a prime example of the controversy over this issue. One court has indicated that despite the FDA's finding that laetrile is not an effective cancer treatment, a cancer patient was entitled to use it. The court based its decision on an obtuse reading of *Wade* and *Bolton*. *Rutherford v. United States*, 399 F. Supp. 1208 (W.D. Okla. 1975).

149. *Coe v. Hooker*, 406 F. Supp. 1072, 1082-83 (D.N.H. 1976); *Klein v. Nassau*

it is established that pregnancy is a condition requiring medical attention, one must merely determine whether abortion is a safe and efficacious response to it at certain medically recognized stages.¹⁵⁰ Obviously the answer must be yes, regardless of the reasons for the abortion, just as prenatal care followed by delivery is also an accepted medical response to pregnancy. Neither choice can be considered unnecessary, despite the existence of alternative forms of medical intervention and despite the fact that the treatments produce different results—a child or no child. Most forms of treatment for a given condition are designed to produce the same result, which may explain why there is such reluctance to apply this analysis to the meaning of “medically necessary” in the context of the abortion issue. Viewed as medical care for the woman patient, both abortion and delivery do produce the same result—a safe termination of the pregnant condition. An analogous condition might be kidney disease, where the choice of treatment is transplant or dialysis. These treatments produce significantly different outcomes with varying consequences and effects on the patient’s lifestyle as well as his or her physical health. Some form of medical treatment for kidney disease is obviously necessary; the choice of treatment is determined by several factors, such as the patient’s ability to accept a transplant and the risk of transplant versus dialysis.

Philosophically, this medical community analysis may sweep too broadly in the Medicaid context, since it would justify providing cosmetic surgery, if, for example, it was necessary to foster mental or emotional health. Yet there may be acceptable policy reasons for not requiring states to pay for such care. *Doe v. Beal* held that the Medicaid statute permits states to limit the medical conditions for which treatment will be provided.¹⁵¹ In any case, this question need not be faced in the Medicaid abortion cases, as the constitutional analysis of *Wade* and *Bolton* does not prohibit a state from limiting choice of treatment for conditions other than pregnancy.

County Medical Center, 347 F. Supp. 496, 500-01 (E.D.N.Y. 1972), *vacated*, 412 U.S. 925-26 (1973). See also *Roe v. Ferguson*, 389 F. Supp. 387, 392 (S.D. Ohio 1974), *rev'd*, 515 F.2d 279 (6th Cir. 1975).

150. The Supreme Court recently acknowledged that states can regulate the methods of abortion to safeguard the mother’s health. But in so doing the Court invalidated a Missouri law prohibiting use of the saline amniocentesis method because, among other reasons it is the prevalent (68%-80%) method of abortion after the first trimester and because no alternatives are generally available. *Planned Parenthood v. Danforth*, 96 S. Ct. 2831, 2845 (1976).

151. 523 F.2d 611, 620-21 (3d Cir. 1975), *cert. granted*, 96 S. Ct. 3220 (1976) (No. 75-554). See also *Legion v. Richardson*, 354 F. Supp. 456 (S.D.N.Y. 1973).

The Supreme Court indirectly considered the issue of what constitutes a medically necessary abortion in *Doe v. Bolton*, where it upheld a section of a Georgia statute making it illegal for a physician to perform an abortion unless, in his "best clinical judgment," it is "necessary."¹⁵² The Court assumed that the physician would base the decision to abort on physical, emotional, psychological, and familial factors, as well as on a consideration of the woman's age.¹⁵³ By adopting this approach, the Court seems to have accepted the proposition that there are "medically unnecessary" abortions, apparently where the factors noted above are absent.

In contrast, the Court also made very clear in *Roe v. Wade* that, at least during the first trimester

the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated. If that decision is reached, the judgment may be effectuated by an abortion free of interference by the State.¹⁵⁴

Thus, at least during the first trimester, an abortion is medically necessary for an individual patient whenever the physician says it is. Unethical physicians are left to the discipline of their licensing boards.¹⁵⁵ This analysis of the medical necessity issue disposes of the

152. 410 U.S. 179, 191-92 (1973). The statute had originally provided that the doctor determine that abortion was necessary to save life or health, was necessary because the fetus was physically or mentally defective, or was necessary because pregnancy resulted from rape. See *id.* at 202. The district court in Georgia deleted the limitations of the reasons which could cause an abortion to be necessary, but it let the statute continue to require a general determination of necessity. *Doe v. Bolton*, 319 F. Supp. 1048 (N.D. Ga. 1970).

153. *Id.* While this assumption may not be justified with respect to the many surgical procedures which have been performed unnecessarily in the United States, there are distinctions between abortions and other types of surgery which suggest that physicians would not perform abortions unnecessarily. It should be noted, however, that there are documented instances of abortion mills providing false pregnancy test results to nonpregnant women and purporting to abort them. *Los Angeles Times*, July 21, 1976, at 3, col. 6. When a patient is told she requires gall bladder surgery or a hysterectomy, she usually has no personal knowledge about whether her gall bladder or uterus must be removed to preserve her physical health. Generally, however, when pregnancy is confirmed, the patient knows whether or not she wishes to terminate her pregnancy by abortion; this operation requires a decision involving social, psychological, and emotional factors as well as physical factors. It is undoubtedly rare that a physician convinces a patient against her judgment to abort a confirmed pregnancy. More frequently a physician convinces a patient to undergo other types of surgery which may often prove unnecessary—that is, surgery performed only for the physician's own financial or professional interest. Perhaps this is the reason that the Supreme Court gave wide latitude to the physician's decision in advising a patient whether to have an abortion.

154. 410 U.S. at 163.

155. See *Doe v. Bolton*, 410 U.S. 179, 200 (1973).

Medicaid abortion problem since any time a physician decides in the first trimester that abortion is in the patient's best interest, it is "necessary" by the Court's definition.

This approach, however, is somewhat unsatisfactory because of its circular reasoning, *i.e.*, abortions are "necessary" if the doctor so concludes in light of physical, emotional, psychological, and familial factors, and the right to privacy precludes any examination of that conclusion. A more direct approach to the problem is available. This approach would recognize that the question of medical necessity arises at the time the condition is discovered. If the condition is one that by its nature may be alleviated by medical attention, then medical care is necessary for this reason alone, regardless of the choices of treatment available. When pregnancy is confirmed, for instance, a condition is presented which requires medical treatment. The physical, psychological, emotional, and familial factors enumerated by the Supreme Court for the physician's consideration may or may not determine the choice among "necessary" treatments, but they do not determine whether the condition of pregnancy requires any "necessary" treatment in the first place.

This postulated approach reaches the same result on the Medicaid abortion question as the analysis derived from *Bolton*. It is, however, less subjective than the Court's approach because it permits one to determine generally whether a condition requires medical care and whether a given treatment is responsive to that condition. The Court's approach in *Bolton* would require an inquiry into whether a proffered treatment is appropriate to an *individual* patient, an inquiry that is itself short-circuited since the state cannot interfere in the doctor-patient decision to have an abortion. Furthermore, this suggested analysis comports with the *Wade-Bolton* protection of choice between medical alternatives by pregnant women. The recognition of such a choice presupposes that the Supreme Court views pregnancy as a condition requiring medical treatment and abortion as one of the several alternative forms of medical treatment.

Under either method of analysis, it would seem that the medical necessity issue is spurious. The question of "medical necessity" is closed once pregnancy is confirmed. Perhaps states may constitutionally limit a physician's general choice of treatment under Medicaid, but they may not do so when the choice involves pregnancy or family planning. States could, for example, refuse to pay for cosmetic surgery, which might be a physician's preferred choice of treatment for an emotional condition that a state might otherwise cover. But the physi-

cian's choice of treatment for pregnancy is protected from interference by the Constitution.

Courts and litigants have not acknowledged that there is no real medical necessity issue and have continued to give substance to the term in the Medicaid abortion context. For instance, in his amicus curiae brief to the Supreme Court on the state's petition for certiorari in *Doe v. Beal*,¹⁵⁶ the solicitor general wrestled with this problem but did not confront the real issue when he defined "medically indicated" to include the factors specified by the Court in *Bolton*. He assumed, as the Court had done, that any physician certifying the medical necessity of an abortion would use those factors in making this decision. However, the solicitor general failed to draw the obvious conclusion from these assumptions: that there are no abortions which would not be medically necessary, aside from those where a physician actually acts against a patient's interest or where the patient is not pregnant.¹⁵⁷

156. Brief for United States as Amicus Curiae for Certiorari, *Doe v. Beal*, 523 F.2d 611 (3d Cir. 1975), cert. granted, 96 S. Ct. 3220 (1976) (No. 75-554).

157. In his brief, the solicitor general made the suggestion that, in order to insure that a doctor was considering all the *Bolton* necessity factors before declaring an abortion necessary, a state could require the doctor to execute a certificate of medical necessity. There is dangerous appeal in this suggestion. Such a requirement is meaningless in light of *Roe v. Wade*, which forbids state interference in the doctor-patient choice to abort in the first trimester. See text accompanying note 154 *supra*. In fact, it is pernicious because it is confusing to administrators and physicians. Some physicians have their own interpretation of when a procedure is medically necessary, such as when care is compelled by a threat to life or health; yet they may prefer to apply a different standard to determine whether an abortion is in their patients' best interest.

Thus, when asked for his definition of medical necessity, Dr. Benjamin Munson, attending physician to Jane Doe, plaintiff in *Doe v. Westby*, testified, "Well, I would say a 'necessary medical procedure'—I hardly ever use the word. I would say, advisable, beneficial. Anything that's necessary without which a person will die, of course that's necessary. Anything without which a person will suffer a serious embarrassment of health, I think that could be called necessary. Beyond that, I suppose very few things are really necessary." Deposition of H. Benjamin Munson, M.D., June 7, 1974, at 13, *Doe v. Westby*, 402 F. Supp. 140 (D.S.D. 1975) (3-judge ct.), appeal docketed, 45 U.S.L.W. 3070 (U.S. July 27, 1976) (No. 75-813). With respect to the "necessity" of an abortion for Jane Doe, Dr. Munson said, "I think 'necessary' is too strong of a word. I wouldn't say necessary, except in terms of preserving the reasonable health that she had, preserving it from depletion and overtiredness and the kind of things that would prejudice a person's general vitality." *Id.* at 17.

Permitting states to require a certificate of medical necessity as a condition to Medicaid abortion payment may interfere with the physician-patient relationship and may impair the physician's ability to prescribe the treatment of choice. Both of these interests were guaranteed protection in *Wade* and *Bolton*. Other measures are available by which states can protect against the only types of "unnecessary" abortions implicitly recognized by the Court in *Wade* and *Bolton*—that is, those abortions where the patient is not ac-

The first court to examine the argument that a state could exclude payment for abortions deemed not medically necessary was the United States District Court for the Eastern District of New York in *Klein v. Nassau County Medical Center*,¹⁵⁸ a case which arose before *Wade* and *Bolton*. The *Klein* court specifically answered the contention that abortions not necessary to preserve life or health may nonetheless fit within the Medicaid law's scheme of medical necessity:

Pregnancy is a condition which in today's society is universally treated as requiring medical care, prenatal, obstetrical and post-partum care, and undeniably it is provided under the Medicaid program as "necessary" medical assistance although pregnancy is not an abnormal condition, nor does the medical assistance in child birth "cure" it. Medical assistance for abortion is not less "necessary" because an election to bear the child would obviate that medical assistance and require instead other, more extensive and more expensive medical assistance.¹⁵⁹

Although the *Klein* decision, when appealed to the Supreme Court, was vacated and remanded for reconsideration in light of *Bolton* and *Wade*,¹⁶⁰ the court's reasoning was so sound that it has been universally accepted. It has, in fact, provided the underpinning of most of the Medicaid abortion decisions to follow.¹⁶¹

In *Doe v. Wohlgenuth*¹⁶² a three-judge district court panel in Pennsylvania swiftly rejected the argument that the Medicaid statute requires payment for abortion. In examining plaintiffs' constitutional

tually pregnant or where the physician acts contrary to the patient's express will or her informed judgment. To avoid the problem of abortifacient acts inflicted upon women who are, for whatever reason, misdiagnosed as pregnant, states can and do license clinics, laboratories, and physicians. To assure that the patient has freely participated in and concurs with the physician's decision, a state may require written consent, as was sanctioned in *Planned Parenthood v. Danforth*, 96 S. Ct. 2831, 2839-40 (1976). By adopting such protective devices a state could guard its legitimate interest in insuring that funds are not used to pay for fraudulent procedures or for those to which the woman did not actually consent. This arrangement would not unduly impair the physician-patient relationship as would the certificate of medical necessity.

158. 347 F. Supp. 496 (E.D.N.Y. 1972), *vacated*, 412 U.S. 925-26 (1973).

159. *Id.* at 500.

160. 412 U.S. 925-26 (1973).

161. See *Doe v. Beal*, 523 F.2d 611, 618 (3d Cir. 1975), *cert. granted*, 96 S. Ct. 3220 (1976) (No. 75-554); *Roe v. Norton*, 522 F.2d 928, 937 (2d Cir.), *on remand*, 408 F. Supp. 660, 664 (D. Conn. 1975), *prob. juris. noted sub nom.* *Maier v. Roe*, 96 S. Ct. 3219 (1976) (No. 75-1440); *Roe v. Ferguson*, 515 F.2d 279, 282 (6th Cir. 1975); *Doe v. Rose*, 499 F.2d 1112, 1116 (10th Cir. 1974); *Coe v. Hooker*, 406 F. Supp. 1072, 1081 (D.N.H. 1976).

162. 376 F. Supp. 173 (W.D. Pa. 1974), *modified*, 523 F.2d 611 (3d Cir. 1975), *cert. granted*, 96 S. Ct. 3220 (1976) (No. 75-554). See notes 113, 151 & accompanying text *supra*, notes 169, 189 & accompanying text *infra*.

arguments, however, the court expressly held unconstitutional the state's limitation of Medicaid funds to "necessary" abortions as defined by the state of Pennsylvania. The court cited *Roe v. Wade* in support of its finding that abortion is by definition a necessary medical service, because "it may prevent specific and direct harm which is medically diagnosable (e.g., psychological harm), may protect the woman's future mental and physical health, and may prevent the distress associated with the unwanted pregnancy and child."¹⁶³

The Third Circuit reversed the district court, holding that the Medicaid statute *does* require the state to pay for abortions.¹⁶⁴ Without dwelling on the problem of medical necessity, the court did find that a state is free to define medical conditions for which treatment is necessary; once having defined them, however, the state must pay for all appropriate medical alternatives that a physician might choose to treat those conditions.¹⁶⁵

Statutory Arguments Supporting State Funding of Abortions

As noted, the Hyde amendment, being a provision governing the expenditures of funds in an appropriations bill, did not amend the Medicaid statute, although it clearly illustrates current congressional feeling on the question of federal funding of abortions. These sentiments, however, do not necessarily establish the intent of Congress in enacting Title XIX.¹⁶⁶ Thus, statutory arguments relating to abortion funding will survive whether or not the Hyde amendment is invalidated, and they will, therefore, be briefly explored.

Comparability Requirements of the Medicaid Statute

The Third Circuit in *Doe v. Beal*¹⁶⁷ developed a creative interpretation of the Medicaid statute by finding that the so-called comparability section of the federal law¹⁶⁸ requires equitable treatment of Medicaid recipients whose physicians choose different modes of therapy for the same condition. Examining Medicaid's statutory language and purposes, the court determined that states have considerable latitude in design-

163. 376 F. Supp. at 190, citing *Roe v. Wade*, 410 U.S. 113, 153 (1973).

164. *Doe v. Beal*, 523 F.2d 611 (3d Cir. 1975), cert. granted, 96 S. Ct. 3220 (1976) (No. 75-554).

165. *Id.* at 621-22.

166. *Doe v. Mathews*, 420 F. Supp. 865 (D.N.J. 1976).

167. *Doe v. Beal*, 523 F.2d 611 (3d Cir. 1975), cert. granted, 96 S. Ct. 3220 (1976) (No. 75-554).

168. 42 U.S.C. § 1396a(a)(10)(B)-(C) (Supp. V, 1975).

ing their Medicaid programs to meet both beneficiary needs and state fiscal requirements;¹⁶⁹ they must, however, exercise their discretion within the statutory limitations.¹⁷⁰ Thus, states may define the types of medical conditions the treatment of which they will subsidize; but once having established those conditions, they may not prescribe the methods for treating them. Such a decision rests exclusively with the attending physician.¹⁷¹

The court reached this conclusion by interpreting sections 1396a(a)(10)(B) and (C) of the statute which dictate equality among Medicaid recipients by requiring that

the medical assistance made available [to the categorically and the medically needy] shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual¹⁷²

The court said that restricting payment for abortion forces "pregnant women to use the least voluntary method of treatment, while not imposing a similar requirement on other persons who qualify for aid."¹⁷³ Thus, the court interpreted the Medicaid statute to include its own "equal protection clause." This analogy is particularly striking in view of the court's recognition that the state could impose some limits on modes of treatment (such as requiring generic drugs to be prescribed or services to be performed in hospitals) but that such restrictions had to be *reasonable*.¹⁷⁴ This analysis is identical to that used by courts in equal protection cases when they seek a rational basis for a state's discrimination between two similarly situated groups.

The *Beal* court examined the state's suggested rationales for limiting Medicaid abortion payments to procedures necessary to preserve life or health and for imposing preconditions upon the abortion procedure.¹⁷⁵ It found that fiscal savings were not a satisfactory reason for refusing payment since abortion is usually the cheapest method of treating pregnancy.¹⁷⁶ Nor was protection of the mother's life a justification for the limitations, since early abortion is conceded to be safer than childbirth.¹⁷⁷

169. 523 F.2d at 616.

170. *Id.* at 616-19.

171. *Id.* at 620.

172. 42 U.S.C. § 1396a(a)(10)(B) (Supp. V, 1975).

173. 523 F.2d at 619.

174. *Id.* at 621.

175. *Id.* at 621-22.

176. *Id.* at 622.

177. *Id.*

Several other courts have adopted the Third Circuit's approach,¹⁷⁸ and none has specifically rejected it, although courts have, in a general way, denied that Medicaid mandates coverage of elective abortions.¹⁷⁹ In addition to disposing of the Medicaid abortion question without resorting to the Constitution,¹⁸⁰ the analysis has broad implications for Medicaid litigation generally, since it permits raising statutory arguments which are similar to those resorted to in constitutional challenges.¹⁸¹ This is important because the Supreme Court has significantly retreated from its earlier liberal position on equal protection, lessening the chances that a constitutional analysis can successfully be applied.¹⁸²

Amount, Scope, and Duration Regulation

As discussed above,¹⁸³ the Medicaid statute does not define the extent to which states may limit Medicaid services; however, an HEW regulation does prescribe boundaries for state restrictions on services. According to this provision, services cannot be so circumscribed that they fail to achieve their purpose,¹⁸⁴ and mandatory services cannot be so limited that they exclude from treatment an illness, condition, or diagnosis.¹⁸⁵ States covering only abortions necessary to protect life or health arguably violate both of these regulatory standards.

178. See *Coe v. Hooker*, 406 F. Supp. 1072, 1082-84 (D.N.H. 1976); *Doe v. Westby*, 402 F. Supp. 140, 143 (D.S.D. 1975), (3-judge ct.), *appeal docketed*, 45 U.S.L.W. 3070 (U.S. July 27, 1976) (No. 75-813); *Doe v. Myatt*, No. 43-74-48 (D.N.D., Oct. 30, 1975).

179. *Roe v. Norton*, 522 F.2d 928 (2d Cir. 1975), *rev'g* 380 F. Supp. 726 (D. Conn. 1974); *Roe v. Ferguson*, 515 F.2d 279 (6th Cir. 1975). See also *Doe v. Rose*, 499 F.2d 1110, 1114-15 (10th Cir. 1974). *Norton* and *Ferguson* turned on the theory that Congress could not have intended to force states into elective abortion coverage, since in 1965, when Title XIX was passed, most states had criminal laws against such abortions. The *Beal* court took issue with this analysis: "It is impossible to believe that in enacting Title XIX Congress intended to freeze the medical services available to recipients at those which were legal in 1965. Congress surely intended Medicaid to pay for drugs not legally marketable under the FDA's regulations in 1965 which are subsequently found marketable. We can see no reason why the same analysis should not apply to the Supreme Court's legalization of elective abortions in 1973." 523 F.2d at 622-23.

180. The Supreme Court prefers that courts decide cases on the basis of statutory, rather than constitutional, arguments whenever possible. *Hagans v. Lavine*, 415 U.S. 528, 543 (1974). *Doe v. Westby*, 383 F. Supp. 1143 (D.S.D. 1974), *vacated*, 420 U.S. 968 (1975) (remanded for consideration of statutory issue first).

181. See, e.g., *White v. Beal*, 413 F. Supp. 1141 (E.D. Pa. 1976).

182. See notes 38-40 & accompanying text *supra*.

183. See notes 66-69 & accompanying text *supra*.

184. 45 C.F.R. § 249.10(a)(5)(i) (1976).

185. *Id.*

Abortions are performed by physicians, often in hospitals, as family planning services. Thus, they involve three mandatory Medicaid services. To determine whether limitations on payment for abortion run counter to the "purpose" standard of the Medicaid regulations, one must first analyze the purpose of each service in question and then examine the abortion limitation to see whether it accomplishes that purpose. The United States District Court for the Eastern District of Pennsylvania applied this approach in *White v. Beal*,¹⁸⁶ where plaintiffs challenged Pennsylvania's Medicaid policy of paying for eyeglasses for patients with eye diseases but not for persons with refractive visual errors, such as nearsightedness, farsightedness, or astigmatism. The court in that case sought a statement of the purpose of providing eyeglasses; finding none in the Medicaid statute, the court used the regulatory definition of eyeglasses as "lenses . . . to aid or improve vision."¹⁸⁷ Since plaintiffs had established that supplying eyeglasses to persons with eye disease almost *never* aids or improves vision, whereas giving lenses to persons with refractive visual errors almost *always* does, the court concluded that the state's limited payment policy did not achieve the purpose of the service.¹⁸⁸

Application of this "purpose" analysis to Medicaid abortion limitations is hampered by the fact that it may be difficult to establish a workable standard of purpose for physician or hospital services. The regulatory definitions of physician and hospital services are so broad as to be useless in this regard. This was the conclusion of the Third Circuit in *Doe v. Beal*¹⁸⁹ when it examined the Medicaid law for definitions of services in a slightly different context. However, because family planning services seem inherently to have a more specific definition, both in public health terms and in the federal regulations, it is possible to define the purposes of such services—for example, spacing children, controlling family size, and avoiding genetic defects.¹⁹⁰ Limiting availability of abortions to those necessary to preserve life or health would thwart these goals, thus failing to meet the purpose standard. Whether this approach would have practical viability depends in large part upon the content of HEW's final family planning abortion regulations, which have yet to be published.¹⁹¹

186. 413 F. Supp. 1141 (E.D. Pa. 1976).

187. *Id.* at 1153, quoting 45 C.F.R. § 249.10(b)(12)(iv) (1976).

188. *Id.* at 1153-54.

189. 523 F.2d 611, 620 (3d Cir. 1975), *cert. granted*, 96 S. Ct. 3220 (1976) (No. 75-554).

190. *See, e.g.*, S. REP. NO. 92-1230, 92d Cong., 2d Sess. 297 (1972).

191. *See* text accompanying notes 207-09 *infra*.

The court in *White v. Beal* also found that the Pennsylvania limits on Medicaid payments for eyeglasses ran afoul of the "scope" standard in the "amount, scope and duration" proviso of the Medicaid regulations by arbitrarily refusing services because of a diagnosis, illness, or condition.¹⁹² Although this standard applies only to the required services for the categorically needy, the court found that once the state chose to cover services for the medically needy,¹⁹³ optional services¹⁹⁴ such as providing eyeglasses became "required" services for the categorically needy within the meaning of the regulation. The court then held that providing eyeglasses to persons with incurable eye disease, while denying them to persons with correctable visual defects, unnecessarily limited required services merely because of a diagnosis of refractive impairment.¹⁹⁵

Whatever the difficulties in using the "purpose" standard to analyze Medicaid abortion limitations, the "scope" standard clearly applies to invalidate programs that restrict payment for abortions to those necessary to preserve or protect life. Physician, hospital, and family planning services are all mandatory services to which the standard obviously applies. Restrictive Medicaid policies deny abortions to healthy women for whom pregnancy is not a health or life threatening condition. Such policies are arbitrary in view of the Supreme Court's holding in *Wade* and *Bolton* that abortion is a matter of choice and may not be limited to those procedures necessary to preserve maternal life or health.

The federal district court in New Hampshire applied this analysis in *Coe v. Hooker*¹⁹⁶ to invalidate New Hampshire's limitations on Medicaid abortions. Finding that the policy arbitrarily excluded healthy women from receiving abortion services, the court disposed of the state's argument that the amount, scope, and duration regulation permitted the restriction by providing: "Appropriate limits may be placed on services based on such criteria as medical necessity or those contained in utilization or medical review procedures."¹⁹⁷ In holding that the state

192. 413 F. Supp. 1141, 1153 (E.D. Pa. 1976), *interpreting* 45 C.F.R. § 249.10(a)(5)(i) (1976). Relying on the regulatory definition of eyeglasses as a visual aid the court rejected the state's attempt to define the condition as eye pathology. 413 F. Supp. at 1154.

193. 42 U.S.C. § 1396a(a)(10)(B) (Supp. V, 1975).

194. *Id.* § 1396d(a)(12).

195. 413 F. Supp. at 1154-55. The court relied heavily on *Doe v. Beal*, 523 F.2d 611 (3d Cir. 1975), *cert. granted*, 96 S. Ct. 3220 (1976) (No. 75-554).

196. 406 F. Supp. 1072 (D.N.H. 1976). See notes 201-02 & accompanying text *infra*.

197. 45 C.F.R. § 249.10(a)(5)(i) (1976).

could not justify limiting abortion benefits by characterizing them as not medically necessary, the court did more than dismiss the medical necessity argument based by the state on *Wade* and *Bolton*. It also found that the state's definition of medical necessity which only included abortions for life or health threatening conditions

create[d] an irrebuttable presumption that an abortion performed on a woman whose pregnant condition does not pose a diagnosable physical health hazard is not "necessary."¹⁹⁸

Citing *Weinberger v. Salfi*,¹⁹⁹ the court held that such a presumption was not rationally related to a legitimate legislative objective because the state's purpose in limiting abortion payments was moral and hence inappropriate.²⁰⁰

Best Interest of the Recipients

In overturning state restrictions on Medicaid abortions, courts have also relied on the federal standard requiring that state Medicaid programs be administered in "the best interests of the recipients . . ." ²⁰¹ The three-judge panel in *Coe v. Hooker* concluded that New Hampshire's abortion restrictions did not meet that requirement. As the court noted, first trimester abortions are conceded to be safer than full term delivery, and the persons most capable of determining whether an abortion is in a particular woman's best interest are the woman and her physician—not the state.²⁰²

Other Statutory Arguments

Plaintiffs in several cases have argued that the regulatory definitions of physician and family planning services implicitly include abortions. These theories, however, have not succeeded.²⁰³ Furthermore, it

198. 406 F. Supp. at 1085.

199. 422 U.S. 749 (1975).

200. *Doe v. Rose*, 499 F.2d 1112, 1117 (10th Cir. 1974).

201. 42 U.S.C. § 1396a(a)(19) (1970).

202. 406 F. Supp. at 1080-81. See note 196 & accompanying text *supra*.

203. "Again, the argument proves too much. Elective cosmetic surgery, for example, is within the licensed practice of medicine in most, if not all, states. If the plaintiffs were correct, the state would be required to pay for such procedures, at the expense, perhaps, of many pressing medical needs of the poor. While § 1903(e) of the original Act may have required the eventual funding of such procedures, its repeal indicates that Congress has no present intention of funding every procedure which falls within the legal practice of medicine. The states are given broad discretion to tailor their programs to their particular needs, and are required to economize and to fund only necessary medical expenses." *Doe v. Beal*, 523 F.2d 611, 620 (3d Cir. 1975), *cert. granted*, 96 S. Ct. 3220 (1976) (No. 75-554).

has already been shown²⁰⁴ that when Congress provided for family planning services under Medicaid, it arguably intended to cover elective abortions, since in other family planning legislation, Congress took care to exclude abortions explicitly.²⁰⁵ Antiabortion advocates could plausibly argue that Congress, by enacting the Hyde amendment, showed that it indeed had the intent of excluding elective abortions when it enacted Medicaid. This argument need not be accepted, since Congress has left its original intent to require state coverage of abortions intact. The Hyde amendment purports to affect nothing more than the funds in the 1977 HEW-Labor appropriations bill, and there is no reason to extend its effect beyond those limited confines.

Apart from congressional intent in providing for family planning services as part of states' responsibility under Medicaid, one may also consider the standard practice of public health experts in defining the scope of such practices. Public health and medical experts will agree that abortion is a *method* of family planning, but not all concur in the assertion that it is an integral part of a family planning program, as it is obviously a rather extreme method of birth control. Nevertheless, a relatively uniform consensus among health care professionals holds that family planning services include such specific techniques as contraception, sterilization, treatment for infertility, and also abortion.²⁰⁶ Abortion serves as a backup method of handling contraceptive failure and as a means of meeting family planning needs where contraception has not been used or provided. It is therefore arguably a necessary element in a comprehensive system of family planning services.

In developing its regulations to implement the 1972 family planning amendment to Medicaid, HEW faced the controversy surrounding abortion. In its proposed regulations of June 13, 1973,²⁰⁷ for purposes of defining the scope of family planning services, the department, consistent with its policy of allowing the states to have complete discretion in deciding whether or not to cover abortions under Medicaid,²⁰⁸ made no reference to abortion. After considerable controversy in 1974, HEW published a revised proposal which would have *excluded*

204. See text accompanying notes 72-76 *supra*.

205. No congressional materials reveal a clear legislative intent on this matter. See 42 U.S.C. § 1396b(a)(5) (Supp. V, 1975); S. REP. No. 92-1230, 92d Cong., 2d Sess. 297 (1972).

206. See Wallace, Goldstine, Gold & Oglesby, *A Study of Title XIX Coverage of Abortion*, 1972 AM. J. PUB. HEALTH 116-20.

207. 38 Fed. Reg. 15582 (1973).

208. See note 156 *supra*.

abortion from the family planning service definition.²⁰⁹ Final regulations are not yet published.

The Congressional Refusal To Provide Funds for Elective Abortions

Because Medicaid is a state administered program, courts have applied constitutional standards to hold that states may not restrict the patient's and physician's choice of treatment for pregnancy. Before the passage of the Hyde amendment, HEW took the position that federal funds were available for abortion if the states chose to provide the service.²¹⁰ Courts never faced the question of how the availability of federal funds related to the constitutional obligations of states under Medicaid to pay for elective abortions. This is a question inextricably bound up in the question of the Hyde amendment's constitutionality, and it is perhaps best to discuss these questions together.

Two reported decisions on the constitutionality of the Hyde amendment appeared soon after the Hyde amendment became law on October 1, 1976. The first decision, *Doe v. Mathews*,²¹¹ was handed down that same day. The decision did no more than deny on procedural grounds²¹² a temporary restraining order against HEW to enjoin the

209. 39 Fed. Reg. 42919-20 (1974).

210. Brief for United States as Amicus Curiae for Certiorari, *Doe v. Beal*, 523 F.2d 611 (3d Cir. 1975), cert. granted, 96 S. Ct. 3220 (1976) (No. 75-554). See also *Roe v. Norton*, 522 F.2d 928, 931 (2d Cir. 1975).

211. 420 F. Supp. 865 (D.N.J. 1976).

212. Judge Biunno noted that a temporary restraining order against the secretary of HEW would be pointless since it is the secretary of the treasury who withdraws the funds in the HEW-Labor appropriations bill. Since the requested TRO was directed only at HEW, the secretary of the treasury would continue to be bound by the Hyde amendment. But see 42 U.S.C. § 1396b(a) (Supp. V, 1975) ("From the sums appropriated therefor, the Secretary [of HEW] shall pay to each State . . ."). In addition, the court expressed doubt that a TRO could be issued to compel the secretary of the treasury to disburse funds, since the Constitution provides: "No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law . . ." U.S. CONST. art I, § 9. The court did express a willingness to consider enjoining the expenditure of any Medicaid funds to coerce Congress into appropriating funds for elective abortions. However, Judge Biunno declined to take such a drastic step in a TRO without the presence of all the parties who would be adversely affected. The court was also unwilling to issue a TRO on the grounds that it would violate the equal protection rights of some of the plaintiffs, since the court had no facts upon which to analyze the claim. In the meantime, Judge Biunno urged that women eligible for Medicaid avoid pregnancy.

Judge Biunno also noted that the state of New Jersey had been enjoined from denying compensation for elective abortions. The state was not made a party to the action, and therefore Judge Biunno declined to rule whether the Hyde amendment was cause for the state to ask that the injunction against it be lifted so that the state could resume its antiabortion policy.

enforcement of the Hyde amendment pending a further hearing on its constitutionality. As a result, the court merely raised issues without resolving them.²¹³

The second decision, *McRae v. Mathews*,²¹⁴ resulted in a nationwide injunction prohibiting the secretary of HEW from giving effect to the Hyde amendment and, in essence, compelling the disbursement of federal funds to the states to cover elective abortions under Medicaid. As of this writing, this injunction is still in effect, and states are receiving funds for their expenses relating to elective abortions.

The plaintiffs in *McRae* included the class of pregnant Medicaid beneficiaries, Planned Parenthood, representing the same group, and the New York City Health and Hospitals Corporation, which provides health services to New York City residents through sixteen municipal hospitals.²¹⁵ HEW presented many objections to the issuance of a preliminary injunction, the most difficult being the claim that no plaintiff has been injured by the Hyde amendment. The rationale suggested by HEW for the absence of harm to plaintiffs in *McRae* was that under state law and under the fourteenth amendment, states would continue to provide the elective abortion services of which plaintiffs claimed they would be deprived by the Hyde amendment.²¹⁶ This claim struck at the plaintiffs' cause of action in three ways. First, plaintiffs had to show irreparable harm and probable success on the merits to receive a preliminary injunction.²¹⁷ Second, plaintiffs had to establish standing to sue on the question of the Hyde amendment, which presupposes that they had been harmed by it.²¹⁸ Third, the plaintiffs had to show that

213. Later in the month, in an unreported decision, Judge Sirica refused to enjoin HEW from enforcing the Hyde amendment. *Doe v. Mathews*, Civil No. 76-1835 (D.D.C. Oct. 21, 1976). Judge Sirica noted that the various jurisdictions supplying the plaintiffs medical services had not yet changed their laws to deny the plaintiffs elective abortions. Until that happened, reasoned the court, none of the plaintiffs had standing to sue.

214. 421 F. Supp. 533 (E.D.N.Y. 1976).

215. *Id.* at 535-36.

216. *Id.* at 537-38. Not mentioned was the fact that Title XIX itself might require these abortions, in spite of the Hyde amendment, which only affects how the federal government will participate in the funding of Medicaid. See notes 166-82 & accompanying text *supra*.

217. FED. R. CIV. P. 65. One of the harms justifying a preliminary injunction in *McRae v. Mathews* was that physicians upon whom Medicaid eligibles depend to provide medical care would be confused by the uncertainty caused by the Hyde amendment and might be deterred from performing abortions.

218. The doctrine of standing is in a state of flux, and its complexities are well beyond the scope of this article. It is worth noting, in regard to the *McRae* case, that recent Supreme Court pronouncements require allegations of "concrete facts demon-

because they were deprived of Medicaid benefits, they were persons denied equal protection of the laws within the meaning of the Constitution.

Judge Dooling found that the plaintiffs had in fact been harmed. According to his analysis, Medicaid is largely a federal program administered with the fiscal and organizational assistance of the states. The federal government was thus characterized as having assumed a "measure of responsibility already to the needy . . . when in Title XIX of the Social Security Act, it laid down the parameters of medical assistance for the needy of the nation."²¹⁹ From this, according to the court:

It follows that withdrawal of reimbursement for elective abortions lawfully performed by licensed providers is *directly* injurious both to the providers and to the indigent women who seek the abortifacient services. . . . It may well be that the state could find funds to assume the responsibility for making the payments, or that private charity could supply the abortifacient services. But that is no more than to say that if the national government unconstitutionally denies an entitlement, catastrophe need not ensue. The answer is that action if unconstitutional, is not tolerable, and is not made tolerable by the consideration that others may make good the harms inflicted by the unconstitutional default. The manifest fact is that [the Hyde amendment] is calculated to stop the provision of abortifacient services from public funds; it is not calculated to shift the burden of providing this medical assistance to the states.²²⁰

Whether the plaintiffs in *McRae* and others similarly situated are actually harmed when the federal government denies reimbursement to the states for the cost of elective abortion services is the question that will determine the constitutionality of the Hyde amendment. It is actually a close question and its answer involves considerable uncertainty.

There is substantial appeal in HEW's argument that whether or not the federal government withholds reimbursement for elective abortions, the states will still be obliged to provide the service to their beneficiaries

strating that the challenged practices harm [the plaintiff], and that he would personally benefit in a tangible way from the court's intervention. Absent the necessary allegations of demonstrable, particularized injury, there can be no confidence of 'a real need to exercise the power of judicial review' or that relief can be framed 'no broader than required by the precise facts to which the court's ruling could be applied.'" *Warth v. Seldin*, 422 U.S. 490, 508 (1975). *See also* *Singleton v. Wulff*, 96 S. Ct. 2868, 2873-74 (1976); *Simon v. Eastern Ky. Welfare Rights Org.*, 96 S. Ct. 1917 (1976). The implication of these cases is that, absent a showing of "harm" caused by the Hyde amendment, the plaintiffs in *McRae* would not have standing to sue the secretary of HEW to enjoin the enforcement of that law.

219. 421 F. Supp. at 538.

220. *Id.*

to the same extent that other pregnancy services are provided to other beneficiaries. States cannot, consistent with the equal protection clause, single out those who wish to exercise their constitutional right to choose abortion over childbirth and treat them differently from other pregnant women, unless they have a compelling reason for doing so. It is doubtful whether the states could argue that they would save funds if they withheld abortions in favor of expensive alternatives for which they could get federal reimbursement. But even if they could, saving public funds does not constitute a compelling state interest justifying infringement of a constitutional right.²²¹

In addition, the method of Medicaid reimbursement suggests that under current procedures Medicaid beneficiaries will continue to receive elective abortion services from the state in spite of the Hyde amendment. Title XIX calls for the state to reimburse providers according to a state plan approved by the secretary of HEW.²²² After considering data from state reports and other sources, the secretary of HEW estimates the federal share of state expenses for the upcoming fiscal quarter. Based on this estimate, the secretary advances appropriate sums of federal money to the states on an installment basis, adjusting payments to account for overpayments or underpayments from the previous quarter.²²³ Title XIX specifies the expenses in which the federal government will share.²²⁴ Of course, a state is free to cover services which are not reimbursable under Medicaid. The Hyde amendment bars the secretary of HEW from disbursing funds to the states to cover elective abortion costs. Thus, the Hyde amendment effectively places elective abortions among the class of nonreimbursable services. The equal protection clause, Title XIX, and HEW's regulations may well require the states to provide elective abortions, but this alone does not make elective abortions federally reimbursable.

Further implications can be drawn from the fact that the state compensates the provider of elective abortions before it is itself reimbursed. If a state decides it wants to eliminate coverage of elective abortions because of the Hyde amendment, or if it wishes to cover only

221. "Of course, a State cannot justify on the basis of fiscal integrity a regulation which would exclude a woman from Medical Assistance reimbursement because she has decided to exercise a constitutional right related to the decision as to whether to bear or beget a child." *Doe v. Wohlgenuth*, 376 F. Supp. 173, 188 (W.D. Pa. 1974), *modified sub nom. Doe v. Beal*, 523 F.2d 611 (3d Cir. 1975), *cert. granted*, 96 S. Ct. 3220 (1976) (No. 75-554). *See also* *Shapiro v. Thompson*, 394 U.S. 618, 633 (1969).

222. *See* 42 U.S.C. §§ 1396a(b), 1396b(a) (1970 & Supp. V, 1975).

223. *See id.* § 1396b(a).

224. *Id.* §§ 1396b, 1396c.

its share of the cost, representing its pre-Hyde amendment share in the service, the state, not the federal government, is the institution which takes the affirmative action to create the illegal classifications between Medicaid beneficiaries. If the state does nothing, providers continue to be reimbursed for elective abortions. Only if the state changes its laws or policies will denial of equal protection result. That the federal government "encouraged" the illegal action is irrelevant, since the federal government is without power to authorize the states to violate the Constitution.²²⁵

Under this reasoning, Medicaid beneficiaries are not directly harmed by the Hyde amendment. Since they have the right to receive elective abortions from the states, they are not being deprived of equal protection of the laws.²²⁶ Absent any but the most speculative harm, they have no standing to challenge the Hyde amendment.²²⁷ They also would be unable to establish the grounds for a preliminary injunction against the federal government, since it is not clear that they would prevail on the merits or that they are being irreparably harmed. This reasoning also comports with the presumption that congressional legislation is constitutional and ought to be interpreted in such a way as to preserve its validity.²²⁸

This reasoning is far from inevitable, and grounding an important ruling of constitutional law on the nature of accounting procedures seems quite unsatisfactory. A finding that the Hyde amendment is constitutional also means that the actions of the federal government, which created the illegal classification, are judicially approved while the natural response of the states—cutting back funding because of the withdrawal of federal funds—is denounced as unconstitutional.

225. See *Shapiro v. Thompson*, 394 U.S. 618, 641 (1969). *Shapiro* dealt with a joint federal-state welfare program. The defendant state governments claimed that Congress authorized the one year waiting periods for welfare benefits which were under attack, since under federal law the secretary of HEW had to approve state welfare legislation. The Supreme Court rejected this statutory construction, denied its relevance to the constitutionality of residency requirements, and commented, "But even if we were to assume, arguendo, that Congress did approve the imposition of a one-year waiting period, it is the responsive *state* legislation which infringes constitutional rights." *Id.* Under this reasoning, any change of abortion reimbursement policy by the states which violates protection rights would be vulnerable to attack in action against the state.

226. An action based on the equal protection clause, of course, would lie against the state government.

227. See note 218 *supra*.

228. *E.g.*, *CSC v. Letter Carriers*, 413 U.S. 548, 571 (1973); *Plymouth Coal Co. v. Commonwealth of Pennsylvania*, 232 U.S. 531, 546 (1914); *cf. Roe v. Norton*, 380 F. Supp. 726, 730 (D. Conn. 1974).

The constitutionality of the Hyde amendment may well depend on whether the states can legally cut back on abortion services as a result of the Hyde amendment, and advocates arguing for continued federal funding of abortions are in an awkward and ironic position indeed. Their case may well depend upon how persuasively they can argue that the states would be justified in denying their clients full funding of elective abortions when other alternative medical care for pregnancy is fully funded.

One way they can do so is to argue that a state which loses the right of reimbursement for the federal share of the cost of elective abortions is not violating the equal protection clause when it takes action to pay providers only the state share of those costs. The state can argue persuasively that accounting conveniences aside, it is funding these services in the same way it did before the Hyde amendment was passed. For equal protection purposes, the state can be viewed as paying for a given percentage of the cost of all pregnancy services, elective abortions included. The state, then, is engaging in no invidious discrimination. The federal government, on the other hand, has chosen to withdraw funding of services from pregnant women exercising their constitutional right to choose abortion free of government interference. Such a line of analysis would place the onus of wrongdoing on the federal government, which is the discriminating government body in the Medicaid abortion context.

The argument that the state government must take affirmative action to change its laws to set up an invidious classification between Medicaid eligibles can also be discounted as the result of a mere accounting convenience. Surely a state could constitutionally arrange for a system in which providers were compensated partly from general state funds but received a separate check from a special account containing only federal reimbursement funds. The state could easily characterize the second part of such a payment procedure as purely "federal" money. Under such a system, the refusal of the state to make up the withdrawn federal share might more plausibly be consistent with the equal protection clause.

Such an extravagant reorganization of accounting methods should not be necessary to make apparent what already exists—a direct federal role in funding Medicaid services. The Supreme Court should look beyond the appearances of the reimbursement procedure and should hold that the Hyde amendment directly injures individual Medicaid beneficiaries and their providers.

If this analysis is accepted,²²⁹ plaintiffs such as those in *McRae* can clearly make out an equal protection claim directly against the federal government.²³⁰ In fact, under equal protection case law, plaintiffs in states which do *not* choose to reduce contributions to elective abortions in light of the Hyde amendment may also have a cause of action against the federal government. The Supreme Court has stated that *potential* denial of equal protection is enough grounds to invalidate a statute.²³¹

229. It should be acknowledged that such an analysis would have potentially widespread repercussions, since the number of federal-state programs has increased exponentially in recent years. The suggested analysis would be available to any recipient of statutory entitlements offered by state governments when the federal government encourages the states to violate the recipient's rights. In the context of federal funding matters, however, both the state and federal government will be immune from equal protection attacks because the desire to save public funds ordinarily provides a rational basis for funding cutbacks. See *Jefferson v. Hackney*, 406 U.S. 535 (1972); *Dandridge v. Williams*, 397 U.S. 491 (1970). The funding of abortions, of course, is an extremely unusual situation because of the inclusion of abortions under the right of privacy.

230. Such an attack, of course, would be brought under the due process clause of the fifth amendment, which includes equal protection concepts. *Shapiro v. Thompson*, 394 U.S. 618, 641-42 (1969); *Bolling v. Sharpe*, 347 U.S. 497 (1954).

231. See *Dunn v. Blumstein*, 405 U.S. 330, 339-40 (1972). The *Dunn* case struck down Tennessee's one year residency requirement for voting. Tennessee had argued that no one had actually been deterred from migrating to Tennessee by the residency requirement and that therefore its enactment did not infringe upon the constitutional right to travel. The Supreme Court rejected the argument, noting that whether persons were actually deterred from exercising their fundamental rights was irrelevant. According to the Court, "the compelling-state-interest test would be triggered by 'any classification which serves to penalize the exercise of that right . . .'" *Id.* at 340. In the Medicaid abortion context, Congress has clearly singled out a class of women who might choose to have an abortion and has sought to penalize that class by withdrawing compensation for those abortions. That a state chooses not to reduce abortion services in light of the Hyde amendment so that no woman's right is actually infringed does not, under the *Dunn* reasoning, render the Hyde amendment any less constitutional. Cf. *McRae v. Mathews*, 421 F. Supp. 533, 538 (E.D.N.Y. 1976).

Although the Hyde amendment may be unconstitutional, the plaintiff in a state not cutting back on abortion services may lack standing to sue under recent Supreme Court cases requiring actual harm and a showing that the challenged conduct caused the harm. See note 218 *supra*. In such a case, the state providing the undiminished abortion services might have standing to challenge the Hyde amendment. It is true that a party cannot generally base standing on the constitutional right of a third party. *Warth v. Seldin*, 422 U.S. 490, 499 (1975). Nor is a state a "person" under the fourteenth amendment such that it could make its own equal protection claim. See *South Carolina v. Katzenbach*, 383 U.S. 301 (1966). A state is *harmed*, however, by the Hyde amendment since it is not receiving reimbursement for elective abortions. The state could argue that the secretary of HEW has no right to base its refusal to reimburse on the unconstitutional Hyde amendment.

As to the process of judicial review of the HEW secretary's refusal to reimburse the states for elective abortions, see 42 U.S.C. § 1316(d) (Supp. V, 1975). This section has its own complexities, which are beyond the scope of this article. Compare *id.* §

Language in *Shapiro v. Thompson*²³² is helpful in challenging the Hyde amendment. In the course of defending their residency requirements for welfare benefits, the states involved in *Shapiro* argued that their welfare plan, including the residency requirement, had to be approved by the secretary of HEW. Therefore, the residency requirements were said to be "authorized" by the federal government. The Supreme Court rejected such a statutory construction, but went on to add this dictum:

[I]t follows from what we have said that the provision, insofar as it permits the one-year waiting-period provision requirement, would be unconstitutional. Congress may not authorize the States to violate the Equal Protection Clause. Perhaps Congress could induce wider state participation in school construction if it authorized the use of joint funds for the building of segregated schools. But could it seriously be contended that Congress would be constitutionally justified in such authorization by the need to secure state cooperation? Congress is without power to enlist state cooperation in a joint federal-state program by legislation which authorizes the States to violate the Equal Protection Clause.²³³

This language clearly militates against a determination that the Hyde amendment is constitutional, provided the view is taken that states can in fact reduce elective abortion services to reflect the diminution of the federal share. Under this view, the Hyde amendment arguably "authorizes" the states to impose a violation of the equal protection clause on Medicaid beneficiaries. Such an authorization, according to *Shapiro*, is beyond Congress' power. On the other hand, if the position is taken that the states must provide complete funding of abortions in spite of the Hyde amendment, the language of *Shapiro* might be of no avail. The Hyde amendment cannot be said to "authorize" a violation of any person's equal protection rights if in fact elective abortions *must* be provided as before.

An entirely different problem was also posed by HEW in the *McRae* case. HEW argued that if the court were to suspend the Hyde amendment and order the appropriation of federal funds, it would be violating article I, section 9 of the Constitution, which provides: "No money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law . . ."²³⁴ This contention was persuasive to

1316(a) (states have a right to review in the court of appeals), *with id.* § 1316(d) (right to ask for reconsideration by the secretary of HEW but no mention of a right to review in the court of appeals). *See also* 5 U.S.C. § 701 (1970) (right to judicial review in district court *unless* "statutes preclude judicial review").

232. 394 U.S. 618 (1968).

233. *Id.* at 641.

234. 421 F. Supp. at 540-41.

Judge Biunno in *Doe v. Mathews*,²³⁵ but Judge Dooling found it to be no impediment to issuing an injunction. Congress was the institution which had appropriated the money, according to Judge Dooling. The court was doing no more than enjoining the effect of an illegal restriction on that appropriation. Thus, "[p]ayment of the funds will follow, but not by an act equivalent to appropriation."²³⁶

Judge Dooling also rejected claims by HEW that the Hyde amendment was not a denial of federal funds to force Medicaid patients into carrying their pregnancies to term but rather was a method of encouraging alternative methods of family planning. The Hyde amendment, he said, could not be validated "by putting it in juxtaposition with the federal encouragement of family planning."²³⁷ The Hyde amendment was thus seen as "a retributive act, not a simple non-invidious decision not to provide a type of medical assistance."²³⁸

On this basis, the Hyde amendment was distinguished from a congressional decision to exclude coverage of longterm inpatient care for the mentally ill. Such a decision was a "reasoned legislative decision . . . free of invidious discrimination . . ." ²³⁹ The Hyde amendment, on the other hand, was the same kind of invidious denial of reimbursement held unconstitutional in numerous federal district court decisions. It infringed on the constitutional right of women on Medicaid to choose abortion over child bearing. Absent a compelling reason for its actions, the government could not refuse to expend monies from its 1977 HEW appropriation on elective abortions.

235. 420 F. Supp. 865, 870-72 (D.N.J. 1976).

236. 421 F. Supp. at 540. The court cited *United States v. Lovett*, 328 U.S. 303 (1946). 421 F. Supp. at 541. In *Lovett*, Congress had attached a rider to an appropriations bill requiring that none of the funds in that bill could be used to pay the salaries of three federal employees suspected of being "subversives." The rider was invalidated as an unconstitutional bill of attainder. The Supreme Court did not find article I, section 9, an obstacle in declaring the rider unconstitutional, thereby releasing funds to pay the salaries of the three employees. See also *Steinberg v. United States*, 163 F. Supp. 590 (Ct. Cl. 1958).

237. 421 F. Supp. at 541. Congressional debates on the Hyde amendment clearly indicate that it was designed simply to prohibit abortions. See, e.g., 122 CONG. REC. H 6648 (daily ed. June 24, 1976) (remarks of Representative Bauman); 122 CONG. REC. H 8634 (daily ed. Aug. 10, 1976) (remarks of Representative Hyde); 122 CONG. REC. S 14562-63 (daily ed. Aug. 25, 1976) (remarks of Senator Helms). The desire to foster family planning was never discussed. See generally 122 CONG. REC. H 8631-41 (daily ed. Aug. 10, 1976); 122 CONG. REC. S 14561-70 (daily ed. Aug. 25, 1976); cf. *Baird v. Eisenstadt*, 429 F.2d 1398, 1401-02 (1st Cir., 1970), *aff'd*, 405 U.S. 438 (1971). But see H.R. REP. No. 94-1555, 94th Cong., 2d Sess. (1976).

238. 421 F. Supp. at 541.

239. *Id.*; see *Legion v. Richardson*, 354 F. Supp. 456 (S.D.N.Y. 1973).

Conclusion

It must be conceded that abortion advocates for Medicaid beneficiaries are forced by the Hyde amendment to argue at cross purposes. On one hand, a woman desiring to obtain an abortion under the Medicaid program and depending upon legal action to get it must proceed against the state government, since it is the state government that will reimburse her provider of services. Therefore, her advocate will want to marshal all the arguments as to why the Constitution, Title XIX, HEW regulations, and state law compel the state to provide elective abortion services among the medical benefits made available to eligible pregnant women. The advocate will, of course, be loath to accept arguments that the Hyde amendment changes any of the law that had previously bound the states. The Hyde amendment, after all, is a restriction on a 1977 appropriations bill and affects nothing beyond the allocation of expenses between the state and federal governments.

On the other hand, advocates wishing to challenge the constitutionality of the Hyde amendment cannot admit that the states are prevented from withholding elective abortion services from Medicaid beneficiaries, since such an admission would be fatal to their challenge. Advocates must show that the Hyde amendment injures their clients directly by disrupting the delivery of elective abortions.

Between the two, the maintenance of laws binding the states is no doubt more important. The Hyde amendment will, of course, disappear within six months unless a similar rider is placed on next year's appropriation. Also, the current law pertaining to the states is very effective in guaranteeing to women on Medicaid the right to choose between abortion and childbearing. These issues will soon be resolved by the Supreme Court. A definitive statement from the Court will lay to rest many of the perplexing legal problems raised in the course of this article.

