ABORTION DELAYED IS ABORTION DENIED: WHY THE HYDE AMENDMENT'S RESCISSION OF FEDERAL FUNDING FOR MEDICALLY NECESSARY ABORTIONS HARMS LOW-INCOME WOMEN

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I. INTRODUCTION

Reproductive health services, protected by the Fifth Amendment[1] "right to privacy," expanded throughout the twentieth century.[2] As women

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gradually attained the freedom to use contraception and to access abortion—and thereby to control their fertility—they became increasingly able to obtain higher education,[3] participate fully in the workforce, and achieve economic stability.[4] However, such gains were not spread equally among socioeconomic classes.[5] While middle- and high-income women benefitted from a range of women's health services, low-income women relied on federal funds to subsidize these services.[6] Unfortunately, the accessibility of federal funds to cover women's health services fluctuated based on the political climate.[7] The Hyde Amendment, enacted in 1977,[8] restricted the use of federal funds for abortion, which had previously been available to low-income women through Medicaid.[9] Under the Hyde Amendment, federal funds were available only when the pregnant woman's *life* was in danger or the pregnancy was the result of rape or incest.[10] "Medically necessary"[11] abortions were not subsidized using federal funds, even when the pregnant woman's health was in jeopardy.[12] Following passage of the Hyde Amendment, low-income women no longer enjoyed

[1] U.S. CONST. amend. V ("No person shall be. . . deprived of life, liberty, or property, without due process of law.").

[2] *See* Skinner v. Oklahoma, 316 U.S. 535 (1942) (protecting a prisoner's right to procreate); Griswold v. Connecticut, 381 U.S. 479 (1965) (holding that preventing married couples from using contraceptives intruded upon the right to marital privacy); Eisenstadt v. Baird, 405 U.S. 438 (1972) (protecting an unmarried woman's ability to obtain and use contraception).

[3] *See* Jill E. Adams & Jessica Aarons, *A Travesty of Justice: Revisiting Harris V. McRae*, 21 WM. & MARY J. WOMEN & L. 5, 46 (2014) ("It is perhaps for the very reason that abortion enables women to pursue educational, financial, and civic opportunities and otherwise determine the course of their own lives that it triggers such intense legal and societal discrimination against the women who have abortions.").

[4] ADAM SONFIELD ET AL., THE SOCIAL AND ECONOMIC BENEFITS OF WOMEN'S ABILITY TO DETERMINE WHETHER AND WHEN TO HAVE CHILDREN, GUTTMACHER INSTITUTE (Mar. 2013), https://www.guttmacher.org/report/social-and-economic-benefits-womens-ability-determine-whether-and-when-have-children. Women's advancements in these areas have led to the narrowing of the gender wage gap since the 1970s. *Id.*

[5] *Id.*

[6] UNINTENDED PREGNANCY IN THE UNITED STATES, GUTTMACHER INSTITUTE (JAN. 2019), https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states. Low-income women also had an unintended pregnancy rate that was five times higher than the rate for higher-income women.

[7] *See* No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act of 2017, H.R. 7, 115TH CONG. (2017).

[8] Hyde Amendment, Pub. L. No. 94-439, 90 Stat. 1418 (1977).

[9] *See* 42 U.S.C. § 1396a (2020) ("Medicaid").

[10] *Id.*

[11] *See infra* note 56, *Simat*, 203 Ariz. at 455-56, for a discussion of the long-term health implications for women who cannot access medically necessary abortions; *see also infra* note 199, *Harris*, 448 U.S. at 339-40 (Marshall, J., dissenting) for a fuller picture of the health implications of the Hyde Amendment.

[12] *Id.*

the same social and economic progress as their higher-income counterparts.[13]

Ana[14] is just one example of a young woman whose life was forever impacted by the Hyde Amendment's harsh funding restrictions. Her story exemplifies the Hyde Amendment's assault on low-income women. Ana was raised in North Philadelphia by a single mother who had given birth to her when she was just sixteen years old. Ana shared an apartment with her two older sisters, each of whom had children of their own. Ana excelled in school and aspired to be a doctor: she hoped that her life would turn out differently from her family members' lives and that she would break the cycle of poverty and teen pregnancy that permeated her community.

Ana suffered from Type I diabetes: she was diagnosed at age six. Her treatments were expensive, but Medicaid made it possible for Ana to manage her disease. In addition to controlling her diabetes, Ana was determined to manage her reproductive health so she could graduate from high school and attend college. She knew where to find the local Planned Parenthood Clinic. She also knew that Planned Parenthood performed abortions, although she did not know anyone who had gotten one.

Ana was seventeen years old when she became pregnant. She discovered that she was eight weeks pregnant during a blood test at an endocrinology appointment. Ana's doctor told her that her pregnancy would endanger her health because of her diabetes and would hinder her ability to continue with her treatments. He advised her to terminate the pregnancy.

At Planned Parenthood, Ana discovered that a first-trimester abortion would cost $400.[15] She was told that because neither her diabetes, nor her pregnancy, were considered "life-threatening," Medicaid would not cover the cost. Ana did not have $400, but she also knew that her health was in jeopardy. By the time Ana scraped together enough money for an abortion, she was sixteen weeks pregnant, and the abortion cost $1000.[16]

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[13] *See* Adams, *supra* note 3, 21 WM. & MARY J. WOMEN & L. at 46.

[14] The individual's name has been changed to protect her privacy. The author met this individual during a summer internship at Planned Parenthood of Southeastern Pennsylvania.

[15] In 2014, an abortion cost approximately $500 at 10 weeks' gestation, whereas at 20 weeks, the cost increased to $1195 or higher. *See* ALINA SALGANICOFF, LAURIE SOBEL & AMRITHA RAMASWAMY, THE HYDE AMENDMENT AND COVERAGE FOR ABORTION SERVICES, KAISER FAM. FOUND. (Jan. 12, 2018), https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services/. *See also* Rachel K. Jones, Meghan Ingerick, & Jenna Jerman, *Differences in Abortion Service Delivery in Hostile, Middle-ground, and Supportive States in 2014*, WOMEN'S HEALTH ISSUES (Jan. 12, 2018), https://www.whijournal.com/article/S1049-3867(17)30536-4/fulltext.

[16] According to one Louisiana study, 29 percent of Medicaid-eligible women surveyed would have had abortions, rather than carried their pregnancies to term, if Medicaid funds had been available to cover their abortions. *See* Sarah C. M. Roberts et al., *Estimating the Proportion of Medicaid-eligable*

Stories like Ana's are too common. Some women jeopardize their health by continuing their pregnancies; others attempt to self-abort. The fact that Ana would be unable to access life-preserving diabetes treatment if she remained pregnant seems just as dangerous as the limited instances of "life endangerment" in which the Hyde Amendment permits the use of Medicaid funds to subsidize abortion.[17]

The Hyde Amendment has recently garnered national attention. The newly-elected president, Joe Biden, has indicated that he would support overturning the Hyde Amendment.[18] Democratic lawmakers have also introduced legislation in recent sessions of Congress that would effectively overturn the Hyde Amendment.[19]

In this Article, I argue that the Hyde Amendment should be overturned because it conflicts with *Roe v. Wade* ("*Roe*"),[20] the landmark Supreme Court decision that protects access to medically necessary abortion throughout all three trimesters of pregnancy. In contrast, the Hyde Amendment does not include a funding provision for the pregnant woman's *health*,[21] but only when the woman's *life*,[22] is in danger.[23] Further, I argue that low-income women seeking medically necessary abortions established a reliance interest in the Medicaid funding that was previously available[24] between the Court's decision in *Roe* and passage of the Hyde Amendment—funding that *is* available for most other medically necessary services.

Pregnant Women in Louisiana Who Do Not Get Abortions When Medicaid Does Not Cover Abortions, BMC WOMEN'S HEALTH (June 19, 2019), https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-019-0775-5.

[17] *See* 42 U.S.C. § 1396a.

[18] *See* Katie Glueck, *Joe Biden Denounces Hyde Amendment, Reversing His Position*, N.Y. TIMES (June 6, 2019), https://www.nytimes.com/2019/06/06/us/politics/joe-biden-hyde-amendment.html ("If I believe health care is a right, as I do, I can no longer support an amendment that makes that right dependent on someone's ZIP code."); *see also 2020 Democratic Party Platform* (July 27, 2020), https://www.demconvention.com/wp-content/uploads/2020/08/2020-07-31-Democratic-Party-Platform-For-Distribution.pdf.

[19] *See* Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act of 2015, H.R. 2972, 114th Cong. (2015); EACH Woman Act of 2017, H.R. 771, 115th Cong. (2017); EACH Woman Act of 2019, H.R. 1692, 116th Cong. (2019); *see also* S. 758, 116th Cong. (2019).

[20] Roe v. Wade, 410 U.S. 113 (1973).

[21] This "medical necessity" provision is important because pregnancy can cause harm that may not be *imminently* life-threatening, but is dangerous nonetheless. *See* Simat Corp. v. Arizona Health Care Cost Containment Sys., 203 Ariz. 454 (2002).

[22] *See infra* note 56, *Simat*, 203 Ariz. at 455-56, for a discussion about the difference between health endangerment and life endangerment during pregnancy.

[23] *Supra* note 8.

[24] *See* McRae v. Califano, 491 F. Supp. 630, 643-45 (E.D.N.Y. 1980).

The Hyde Amendment stole the newfound gains in employment and education from low-income women who rely on public assistance to subsidize safe, legal abortions when their health is in jeopardy. Furthermore, the Hyde Amendment endangers women's health, as Medicaid recipients who cannot afford abortions are often forced to risk their health by carrying their pregnancies to term.[25]

Part II of this Article explores the history of abortion access in the United States. It focuses on *Roe v. Wade*,[26] on the history and substance of the Hyde Amendment,[27] on *Harris v. McRae* (the principal challenge to the Hyde Amendment)[28] and its four dissenting opinions, and on *Planned Parenthood v. Casey*,[29] in which the Court cited a "reliance interest"[30] as an important reason to reaffirm *Roe*. In Part III, I explore the reasons why a woman would reasonably rely on federal funding for abortion. Specifically, before the Hyde Amendment was implemented, funds for medically necessary abortions *were* accessible. In Part IV, I argue that the Hyde Amendment should be overturned because it conflicts with *Roe* and *Casey*: specifically, the Hyde Amendment eliminated the use of federal funds for medically necessary abortions for low-income pregnant women who previously relied on them. I also consider the four dissenting opinions in *Harris v. McRae*—which address the problematic lack of a "health" exception in the Hyde Amendment—in order to highlight the fact that abortion rights advocates were left just *one* vote shy of enshrining women's health protections for low-income women under law when the case was decided in 1980.

II. HISTORY OF ABORTION ACCESS IN THE UNITED STATES

Several federal programs allot funding for family planning services: however, Title X[31] bars the use of federal funds for abortion, and Medicaid[32] severely limits federal funding for abortion to the circumstances

[25] *See infra* note 56, *Simat*, 203 Ariz. at 455-56.

[26] *Roe*, 410 U.S. 113 (1973).

[27] 42 U.S.C. § 1396a.

[28] Harris v. McRae, 448 U.S. 297 (1980).

[29] Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992).

[30] *Id.* at 856. Women "detrimentally rely" on access to abortion when they assume that the procedure will be available if necessary but, when they most need this service, they discover that it is unavailable.

[31] Pub. L. No. 91-572 (1970). The Title X Family Planning Program, part of the Public Health Service Act, was signed into law by President Nixon in 1970. It prohibited funding for "programs using abortion as [a] family planning method." However, contraception and childbirth services were subsidized.

[32] 42 U.S.C. § 1396a.

enumerated in the Hyde Amendment. Currently, 14.2 million women of reproductive age[33] are enrolled in Medicaid.[34] This figure represents 20 percent of U.S. women of reproductive age.[35]

Title XIX of the Social Security Act ("Medicaid") was passed in 1965 to provide "medically necessary" health services to low-income individuals.[36] Medicaid provides federal funds for health care services to states that participate in the program.[37] States are not required to participate in Medicaid; however, participating states are required to comply with specific Medicaid funding obligations.[38] Abortion was not covered under the "family planning services" section when Medicaid was passed,[39] nor was it explicitly excluded.[40] However, between *Roe v. Wade*[41] in 1973 and the Hyde Amendment[42] in 1977, many states used Medicaid dollars to fund abortions.[43]

A. Roe v. Wade

Eight years after Medicaid was implemented, the Supreme Court held in the landmark 1973 decision *Roe v. Wade* that a pregnant woman's "right

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[33] "Reproductive age" is defined as ages 15-49. *See* UNINTENDED PREGNANCY IN THE UNITED STATES, *supra* note 6.

[34] ALINA SALGANICOFF, LAURIE SOBEL, & AMRUTHA RAMASWAMY, THE HYDE AMENDMENT AND COVERAGE FOR ABORTION SERVICES, KAISER FAMILY FOUNDATION (Sept. 10, 2020), https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services/. The Hyde Amendment also restricts abortion funding for individuals covered by the Indian Health Service and the Children's Health Insurance Program ("CHIP"). *Id.*

[35] *Id.* Furthermore, "in 2018, half (50%) of women below the Federal Poverty Level (FPL) were insured by Medicaid."

[36] 42 U.S.C. § 1396a. Medicaid recipients were referred to in the Medicaid Act as the "categorically needy." States could also choose to cover additional recipients (the "medically needy"). The Medicaid Act appropriates funds annually,

enabling each State, as far as practicable under the conditions in such State, to furnish (1) 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, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.

Id.

[37] *Id.*

[38] *Id.* Medicaid required states to provide five general categories of medical services: (1) inpatient hospital services; (2) outpatient hospital services; (3) laboratory and x-ray services; (4) skilled nursing facilities, screening and treatment for individuals under the age of twenty-one, *and family planning services and supplies*; and (5) physician services. Eligibility for Medicaid is based on two criteria: medical need and financial need (emphasis added).

[39] Medicaid was enacted before *Roe v. Wade* legalized abortion in certain circumstances.

[40] *See* 42 U.S.C. § 1396a.

[41] *Roe*, 410 U.S. 113 (1973).

[42] 42 U.S.C. § 1396a.

[43] *See infra* notes 107-10.

to privacy"[44] included the right to terminate her pregnancy.[45] This right was not absolute, however: as the stages of pregnancy progressed, states could enact "reasonable" restrictions to protect the interests of both (1) preserving the life *and health* of the mother and (2) protecting potential life.[46] In *Roe*, plaintiff Jane Roe challenged Texas's criminal abortion statute, which only permitted abortion to save the pregnant woman's life.[47] The Court held that this statute violated the Due Process Clause of the Fourteenth Amendment for several reasons.[48] First, the statute did not consider the competing interests of the pregnant woman and the "potential life."[49] Second, it did not differentiate between stages of pregnancy, even though fetal development continues over the course of three trimesters of pregnancy.[50] Finally, the Texas statute did not consider the mother's health to be a "reasonable" exception for which abortion should be available.[51]

In *Roe*, the Court delineated "reasonable restrictions" for access to abortion based on the three trimesters of pregnancy.[52] In the first trimester, the right to choose to terminate the pregnancy must be left to the pregnant woman and her doctor.[53] In the second trimester, the state may, "in promoting its interest in the health of the mother," promulgate regulations "in ways that are reasonably related to maternal health."[54] However, in the third trimester, the state's interest in protecting the "potentiality of human life" may outweigh most other considerations.[55] The state may regulate—and even prohibit—abortion, except to preserve the life *or health*[56] of the mother, as determined by a physician.[57]

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[44] This "right to privacy" was determined to be a "fundamental right" and was therefore subject to "strict scrutiny." States therefore needed to show a "compelling state interest" in order to uphold restrictive abortion statutes. In determining this, the Court relied on previous "marital" and "childbearing" fundamental right-to-privacy decisions, such as *Griswold* (protecting the right of married couples to obtain and use contraception based on the right to "marital privacy"). *See* U.S. CONST. amend. V; *see also Eisenstadt*, 405 U.S. 438 (protecting a single woman's right to contraceptives).

[45] *Roe*, 410 U.S. at 120.

[46] *Id.* at 163 (emphasis added).

[47] *Id.* at 120.

[48] *Id.* at 164.

[49] *Id.*

[50] *Id.* at 166.

[51] *Id*. at 168.

[52] *Id.* at 170.

[53] *Id.* at 172.

[54] *Id.* at 173.

[55] *Id.* at 164-65.

[56] Many long-term health consequences can result when women are denied access to abortion, some of which will later be fatal (but are not considered life-threatening during pregnancy). *See Simat*, 203 Ariz. 454 (2002). These include:

In addition to protecting a woman's fundamental right to choose to terminate her pregnancy, the Court emphasized the importance of protecting both the life and the health of the mother throughout the entire pregnancy, even as additional restrictions were placed on elective abortions.[58] Even as the state's interest in "potential life" increased, the woman's health remained an important consideration.[59] Preserving maternal health, in addition to maternal life, has been upheld as an important exception to abortion restrictions.[60]

While a woman's right to terminate her pregnancy is not absolute, a statutory barrier to abortion access also need not be absolute in order to be invalidated as unduly burdensome.[61] In *Doe v. Bolton*, the Court determined that a Georgia requirement that a hospital committee review a doctor's medical determination that a first-trimester abortion was medically necessary before a woman could access an abortion was "unduly restrictive of the patient's rights and needs."[62] The statute was therefore invalidated.[63] Furthermore, obstacles to abortion access such as spousal or parental consent laws[64] have been invalidated in light of the Court's decision in *Roe*.[65]

> [C]ancer, for which chemo- or radiation therapy ordinarily cannot be provided if the patient is pregnant, making an abortion necessary before proceeding with the recognized medical treatment . . . Other conditions for which the administration of drug or other therapy regimens must at times be suspended during pregnancy [include] heart disease, diabetes, kidney disease, liver disease, chronic renal failure, asthma, sickle cell anemia, Marfan's syndrome, arthritis, inflammatory bowel disease, gall bladder disease, severe mental illness, hypertension, uterine fibroid tumors, epilepsy, toxemia, and lupus erythematosus. In many of the women suffering from these diseases, suspension of recognized therapy during pregnancy will have serious and permanent adverse effects on their health and lessen their life span.

Id. at 455-56.

[57] *Roe*, 410 U.S. at 165. The pregnant woman's health—not just her life—was protected during *all three trimesters* of pregnancy.

[58] *Id.*

[59] *Id.*

[60] *See, e.g.*, Stenberg v. Carhart, 530 U.S. 914, 937-38 (2000) (invalidating a Nebraska abortion statute because it did not carve out an exception for the "health" of the mother). The Court held that "the absence of a health exception will place women at unnecessary risk of tragic health consequences." Further, "Nebraska has not convinced [this Court] that a health exception is 'never necessary to preserve the health of women.'" *Id.*

[61] *See* Doe v. Bolton, 410 U.S. 179 (1973); *see also* Bellotti v. Baird, 443 U.S. 622 (1979) (holding that a Massachusetts parental consent law with no separate judicial bypass procedure for cases in which the minor could not involve her parents in her decision was "unduly burdensome").

[62] *Doe*, 410 U.S. at 198.

[63] *Id.*

[64] "Parental consent" laws require minors to obtain written permission from one or both parents before they can obtain abortions. UNINTENDED PREGNANCY IN THE UNITED STATES, *supra* note 6.

[65] Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 53 (1976).

B. Additional Considerations for Abortion Access

The cost of an abortion varies by state, by week and trimester of pregnancy, by method of abortion[66], and by type of health insurance. One 2013 study[67] by the Guttmacher Institute provides insight into the financial burdens faced by many women[68] seeking abortions.[69] The average cost of a first trimester abortion was $485.[70] A second trimester abortion can cost significantly more, around $854.[71] This does not include substantial ancillary expenses such as transportation, childcare, lost wages from taking time off from work, and hotel costs[72] in some cases.[73] The majority of second trimester abortions were paid for with private health insurance.[74] To cover the cost of an abortion, one third of the women surveyed were forced to forgo paying bills, rent, or food expenses.[75]

In addition to differences in the cost of abortion between states, differences among states in the general accessibility of abortion may contribute to increased costs.[76] Some states have many clinics, whereas others have very few: if women are forced to travel greater distances, the ancillary expenses increase.[77] In addition, state laws mandating 24-, 48-, or 72-hour waiting periods and ultrasounds often increase the number of trips that women must take and the costs that they must incur before they are able to access abortion.[78]

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[66] There are two methods of abortion: medication abortion (Mifepristone, also known as RU-486) and surgical abortion. Mifepristone is effective through the first ten weeks of pregnancy. THE AVAILABILITY AND USE OF MEDICATION ABORTION, KAISER FAMILY FOUNDATION (Oct. 11, 2018), https://www.kff.org/womens-health-policy/fact-sheet/medication-abortion/.

[67] The study analyzed data compiled between 2009 and 2012.

[68] Approximately one third of U.S. women will undergo an abortion before age 45. *Id*.

[69] Rachel K. Jones et al., *At What Cost? Payment for Abortion by U.S. Women*, 23 WOMEN'S HEALTH ISSUES 173-78 (2013), https://www.researchgate.net/publication/236674611_At_What_Cost_Payment_for_Abortion_Care_by_US_Women.

[70] *Id*. A few of the patients surveyed paid $3500 or more.

[71] *Id.*

[72] In states with mandatory waiting periods (between 24 and 72 hours), women are forced to return for a second appointment before they can undergo the procedure. This significantly increases the ancillary expenses that women incur. *See* COUNSELING AND WAITING PERIODS FOR ABORTION, GUTTMACHER INSTITUTE (Mar. 1, 2021), https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion.

[73] *Id.* Transportation, lost wages, and childcare averaged $44, $198, and $57, respectively.

[74] *Id.* Low-income women seeking second trimester abortions cited the difficulty of finding enough money to pay for the procedure as the reason for delaying the procedure until later in their pregnancies.

[75] *Id.*

[76] *Id.*

[77] *See* Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2315 (2016).

[78] *See* Jones et al., *supra* note 69, 23 WOMEN'S HEALTH ISSUES at 173-78.

C. The Hyde Amendment

Following *Roe*, anti-choice lawmakers quickly moved to impose restrictions on a woman's constitutionally protected right to terminate a pregnancy. In 1977, Congress enacted the Hyde Amendment,[79] named after the bill's sponsor, Congressman Henry Hyde.[80] The original bill[81] only allocated federal funding for abortions to preserve the pregnant woman's life and in cases of rape or incest that were "promptly reported" to law enforcement.[82] However, for abortions that were medically necessary[83] as determined by a physician but not life threatening, the Hyde Amendment did *not* provide subsidies.[84] The Hyde Amendment's failure to cover medically necessary abortions differentiated it from the Court's decision in *Roe*, because *Roe* protected access to medically necessary abortion throughout all three trimesters of pregnancy.[85] Because the Medicaid program relies on federal funds, courts have often interpreted this to mean that the Hyde Amendment altered Medicaid's funding requirements such that states were no longer required to fund medically necessary abortions for which federal funds were unavailable.[86] The Hyde Amendment's stated intent was to limit abortion in order to "protect potential life."[87]

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[79] *Supra* note 8. The Hyde Amendment was part of the Departments of Labor and Health, Education, and Welfare Appropriation Act of 1977: it was signed in 1976 but did not go into effect until 1977. *Id.* It was immediately challenged by pregnant welfare recipients seeking abortions, physicians who provided abortions to low-income women, and pro-choice groups in several states. *See Harris*, 448 U.S. 297 (1980).

[80] Congressman Hyde was a vocally anti-choice Republican from Illinois. Regarding his anti-choice advocacy, he later stated, "We tell poor women, 'You can't have a job. You can't have a good education. You can't have a decent place to live. I'll tell you what we'll do. We'll give you a free abortion, because there are too many of you people, and we want to kind of refine the breed.' And I tell you, if you read the literature, that's what's said and that's what's done." Julie Rovner, *Hyde Leaves Complex Litigation Legacy*, NPR (Nov. 29, 2007), https://www.npr.org/templates/story/story.php?storyId=16747707.

[81] The Hyde Amendment was fiercely debated over six months of emotional hearings and twenty-five roll call votes. *See also* Hodgson v. Board of County Comm'rs, 614 F.2d 601 (8th Cir. 1980).

[82] Hyde Amendment, *supra* note 8. In some, but not all, of the early amended versions of the Hyde Amendment, "medically necessary" abortions were included in the bill's language. *See Califano*, 491 F. Supp. at 642. The 1978 version of the Hyde Amendment included the phrase "severe and long-lasting physical health damage," but this language was removed in 1980. *Id.*

[83] "Medically necessary" means that carrying the pregnancy to term is associated with serious health issues but is not imminently fatal. *See supra* note 56, *Simat*, 203 Ariz. at 455-56. *Roe* in contrast, protected a woman's right to choose in order to preserve her *health* through all three trimesters of pregnancy. *See Roe*, 410 U.S. 113 (1973).

[84] *See supra* note 8.

[85] *Roe*, 410 U.S. at 165.

[86] 42 U.S.C. § 1396(a)(17) (2020); 42 C.F.R. § 440.230(c)(1) (2020). Furthermore, "nothing in Title XIX [Medicaid] as originally enacted, or in its legislative history, suggests that Congress intended to require a participating State to assume the full costs of providing any health services in its Medicaid plan. Quite the contrary, the purpose of Congress in enacting Title XIX was to provide federal financial

The Hyde Amendment was immediately challenged when it went into effect in 1977.[88] Since 1977, the Hyde Amendment has been amended several times, and it was incorporated into the No Tax Payer Funding for Abortion and Abortion Insurance Full Disclosure Act of 2017.[89]

D. State Limits on Abortion

In addition to the Hyde Amendment, some states passed their own statutes limiting the use of either state funding or Medicaid dollars—or both—to subsidize abortion. In *Maher v. Roe*,[90] two indigent women who were unable to obtain waivers for medically necessary abortions challenged a 1975 Connecticut welfare statute limiting the use of state Medicaid funds to subsidize only "therapeutic"[91] first trimester abortions.[92] The arguments raised by the plaintiffs in *Maher* were similar to those raised in later challenges to the Hyde Amendment.[93] The plaintiffs argued that limiting funds to subsidize only medically necessary abortions was (1) inconsistent with the state's Title XIX funding requirements and (2) violated their Fourteenth Amendment rights to due process and equal protection.[94]

The Court in *Maher*[95] held that the Fourteenth Amendment's Equal Protection Clause did not require the state of Connecticut to subsidize

assistance for all legitimate state expenditures under an approved Medicaid plan." *Harris*, 448 U.S. at 308.

[87] *Califano*, 491 F. Supp. at 641. One issue raised by opponents of the Hyde Amendment is that it would disproportionately harm minority women: specifically, African American and Hispanic women. *Id.*

[88] *See Harris*, 448 U.S. 297 (1980).

[89] H.R. 7, 115th Cong. (2018). Medically necessary abortions are not covered under this current version of the Hyde Amendment.

[90] Maher v. Roe, 432 U.S. 464 (1977). The reasoning in *Maher*, including the argument that "indigency" was not a suspect class, provided the basis for the Court's subsequent decision three years later in *Harris*. *See Harris*, 448 U.S. 297 (1980).

[91] "Therapeutic" abortions are medically necessary. "Nontherapeutic," also known as "elective," abortions are those that are "not necessary for health reasons." Cynthia Soohoo, *Hyde-Care for All: The Expansion of Abortion-Funding Restrictions Under Health Care Reform*, 15 CUNY L. REV. 391, 395-96 (2012). In *Maher*, therapeutic abortions were covered under the Connecticut statute. *Maher*, 432 U.S. at 467. This differentiates *Maher* from *Harris*, in which even therapeutic abortions were not covered. *See supra* note 28, *Harris*, 448 U.S. at 313-14. In *Harris*, the issue of nontherapeutic abortion was not raised. *Id.*

[92] *Maher*, 432 U.S. at 466-67.

[93] Some cases challenged the withholding of funds for elective abortions, whereas others challenged the withholding of funds for medically necessary abortions.

[94] *Maher*, 432 U.S. at 467.

[95] However, the District Court held that the Connecticut regulation did in fact violate "the Equal Protection Clause of the Fourteenth Amendment because the unequal subsidization of childbirth and abortion impinged on the 'fundamental right to abortion' recognized in [Roe] and its progeny." *Harris*, 448 U.S. at 313.

nontherapeutic abortions even if it did subsidize expenses incident to childbirth.[96] Connecticut could make a "value judgment"[97] favoring childbirth over abortion and could allocate its limited state welfare dollars accordingly.[98] Further, "indigency" was not a "suspect class" for equal protection purposes; therefore, the plaintiffs' "fundamental right to privacy" claim was not subject to strict scrutiny.[99] The Court applied the much less stringent "rational basis test" because the Connecticut statute neither targeted a suspect class nor impinged upon a fundamental right.[100] The Court determined that the Connecticut statute was rationally related to the state's "strong and legitimate interest in encouraging normal childbirth" over abortion.[101]

In addition, the Court in *Maher* concluded that the Connecticut statute did not impinge upon a woman's fundamental right to privacy because the statute did not erect an additional "obstacle" to abortion access.[102] By limiting the use of federal funds to only medically necessary abortions, Connecticut had not made indigent women "worse off" than they were before the statute was implemented.[103] The affected women had previously relied on, and thereafter continued to rely on, private funds for elective

[96] *Maher*, 432 U.S. at 470.

[97] Specifically,

> *Roe* did not declare an unqualified "constitutional right to an abortion," as the District Court seemed to think. Rather, the right protects the woman from unduly burdensome interference with her freedom to decide whether to terminate her pregnancy. It implies no limitation on the authority of a State to make a value judgment favoring childbirth over abortion, and to implement that judgment by the allocation of public funds.

Id. at 473-74.

[98] *Harris*, 448 U.S. at 314. Specifically,

> [t]he Connecticut regulation places no obstacles—absolute or otherwise—in the pregnant woman's path to an abortion. An indigent woman who desires an abortion suffers no disadvantage as a consequence of Connecticut's decision to fund childbirth; she continues as before to be dependent on private sources for the service she desires. The State may have made childbirth a more attractive alternative, thereby influencing the woman's decision, but it has imposed no restriction on access to abortions that was not already there. The indigency that may make it difficult—and in some cases, perhaps, impossible—for some women to have abortions is neither created nor in any way affected by the Connecticut regulation.

Id.

[99] *Id.* at 299.

[100] *Id.*

[101] *Maher*, 432 U.S. at 479.

[102] *Id.* at 474 ("The indigency that may make it difficult, and in some cases, perhaps, impossible for some women to have abortions is neither created nor in any way affected by the Connecticut regulation . . . [it therefore] does not impinge upon the fundamental right recognized in *Roe*.").

[103] *Id.*

abortions.[104] Finally, the Court held that Title XIX funding requirements provided states with discretion regarding the allocation of their limited funds.[105]

Throughout the 1980s, other states moved to protect access to abortion for marginalized women, thereby exercising discretion in allocating both state and Title XIX funds.[106] Several states, including California,[107] Minnesota,[108] Connecticut,[109] and New Jersey,[110] subsidized abortions for low-income women.[111] The total number of abortions performed annually during this period rose steadily, from 615,831 abortions in 1973 to 988,267 abortions in 1976.[112] However, while the number of early abortions increased,[113] the number of later-term abortions declined[114] in number.[115]

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[104] *Id.*

[105] *Id.* at 480. The issue of Title XIX funding requirements was discussed briefly in *Maher*. However, it was discussed in much greater detail in the cases following it, including *Harris*. *See Harris*, 448 U.S. 297 (1980).

[106] *See infra* notes 107-10.

[107] Comm. to Defend Reprod. Rights v. Myers, 625 P.2d 779 (Cal. 1981) (noting that California's version of Medicaid, known as Medi-Cal, covered abortion until legislation resembling the Hyde Amendment was passed in 1978). Specifically, "the restrictions at issue here directly impede this fundamental purpose. Even when an abortion represents the appropriate medical treatment for a poor pregnant woman, the statute virtually bars payment for that treatment and thus subjects the poor woman to significant health hazards and in some cases to death." *Id.* at 790.

[108] Women of the State of Minnesota v. Gomez, 542 N.W.2d 17, 23 (1995) (following *Roe*, Minnesota began to reimburse for all abortions performed by licensed providers).

[109] Doe v. Maher, 515 A.2d 134, 135-136 (Conn. Sup. Ct. 1986). Following *Roe*, Connecticut began to cover therapeutic abortions.

[110] Right to Choose v. Byrne, 450 A.2d 925, 928 (N.J. 1982). Between *Roe* and the passage of a 1975 law limiting funding, New Jersey did not restrict funding for abortion.

[111] Currently, 16 states use Medicaid dollars to fund "all or most" medically necessary abortions for Medicaid recipients—seven do so voluntarily, and nine do so pursuant to court orders. GUTTMACHER INST., STATE FUNDING OF ABORTION UNDER MEDICAID (2020), https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid.

[112] *Califano*, 491 F. Supp. at 634. Statistics were drawn from the 1975 Abortion Surveillance Report and the 1976 "pre-published tables" from the Centers for Disease Control and Prevention ("CDC"). The number of abortions rose each year between 1969 and 1976. *Id.* The number of abortions in 1969 was 22,670 and the number of abortions per 1,000 live births was 6.3, with 10 states reporting. *Id.* In 1973, these numbers were 615,831 annual abortions and 196.3 abortions per live births, with 50 states, plus the District of Columbia, reporting. *Id.* In 1976, these numbers were 988,267 annual abortions and 312 abortions per 1,000 live births, with all 50 states plus D.C. reporting. *Id.*

[113] *Id.* The percentage of annual abortions performed at 8 weeks gestation or less ("early abortions") was 34 percent in 1972, 36.1 percent in 1973, 42.6 percent in 1974, 44.6 percent in 1975, and 47 percent in 1976. *Id.* The percentage of abortions performed between 9 and 10 weeks gestation remained relatively stable, from 30.7 percent in 1972, to 29.4 percent in 1973, and down to 28 percent in 1976. *Id.*

[114] *Id.* at 635. For the 11-12 week gestation period ("later abortions"), the percentage of abortions declined from 17.5 in 1972 (or 17.9 in 1973), to 15.4 in 1974, to 14.9 in 1975, and to 14.4 in 1976. *Id.* For the 13-15 week gestation period, these figures were 8.4 in 1972, 6.9 in 1973, 5.5 in 1974, 5 in 1975, and 4.5 in 1976. *Id.* In the 16-20 week gestation period, the percentage of annual abortions performed

Abortion becomes increasingly expensive as the trimesters progress: "early" abortions are significantly less expensive than "later" abortions.[116] In the mid-1970s, following *Roe*, the Department of Health, Education and Welfare[117] ("DHEW") funded approximately 300,000 abortions, financed in large part through Medicaid.[118] However, following the implementation of the Hyde Amendment in 1977, the number of abortions sharply declined, and the number of pregnancies resulting in live births increased.[119]

The Court again addressed the issue of Title XIX funding requirements in *Beal v. Doe*,[120] where the Court reviewed a Pennsylvania law that restricted the use of Medicaid funds for abortions to instances in which the procedure was determined by a physician to be "medically necessary."[121] The Court determined that Title XIX does not require states to fund nontherapeutic[122] abortions as a condition for participation in the Medicaid program, even if the state exercises its discretion and funds medically necessary abortions, pregnancy services, and childbirth.[123] The statute at issue provided funding for *medically necessary* abortions, however: in fact, the Court noted that refusing to fund medically necessary abortions, while funding other medically necessary services under Title

between 16 and 20 weeks declined from 8.2 in 1972, to 8 in 1973, to 6.5 in 1974, to 6.1 in 1975, and finally, to 5.1 in 1976. *Id.*

[115] Following *Roe*, as more women were able to access abortion more easily, they were also able to terminate their pregnancies earlier in the pregnancy. *See* PLANNED PARENTHOOD, ABORTION AFTER THE FIRST TRIMESTER IN THE UNITED STATES (Jan. 2015), HTTPS://WWW.PLANNEDPARENTHOOD.ORG/UPLOADS/FILER_PUBLIC/99/41/9941F2A9-7738-4A8B-95F6-5680E59A45AC/PP_ABORTION_AFTER_THE_FIRST_TRIMESTER.PDF.

[116] *See* Jones et al., *supra* note 69, 23 WOMEN'S HEALTH ISSUES at 173-78.

[117] In 1979, DHEW separated into two cabinet agencies: the Department of Health and Human Services ("HHS") and the Department of Education. *See* Alan P. Balutis, *The Reorganization of DHEW: What Happened, Why, and So What?*, JOURNAL OF HEALTH AND HUMAN RESOURCES ADMINISTRATION, Vol. 1(4) (May 1979), 504-25.

[118] *Califano*, 491 F. Supp. at 639. ("Before the enactment of the Hyde Amendment . . . DHEW had regularly paid the federal share of the cost of abortions performed under approved State plans for Medicaid eligibles.") *Id.* at 640. Further, one 1977 study by the National Center for Health Statistics indicated that fewer births would have occurred if the women surveyed had only given birth to "wanted" children. *Id.* at 639. ("One-fifth of all births to mothers aged 15-44 would not have occurred if the women had given birth only to those babies they reported as 'wanted' at the time of conception.") *Id.*

[119] *See* Carol C. Korenbrot, Claire Brindis, and Fran Priddy, *Trends in rates of live births and abortions following state restrictions on public funding of abortion*, PUBLIC HEALTH REPORT, Vol. 105(6) (Nov.-Dec. 1990), 555-62.

[120] Beal v. Doe, 432 U.S. 438 (1977).

[121] *Id.* at 447.

[122] Abortions that are not medically necessary. *See supra* note 91, Soohoo, 15 CUNY L. REV. at 395-96.

[123] *Beal*, 432 U.S. at 441.

XIX, could raise "serious statutory questions."[124] However, the Court held that states need not subsidize services that are not medically necessary.[125] Additionally, the Court indicated that states may adopt "reasonable standards" to select services to subsidize and to determine those which are "consistent with the objectives of [Title XIX]."[126] Finally, the Court stated that a state has a strong interest in "encouraging childbirth."[127]

E. Harris v. McRae

In the seminal case challenging the Hyde Amendment, *Harris v. McRae* ("*Harris*"), the plaintiffs—pregnant Medicaid recipients and abortion providers—responded to the 1977 implementation of the Hyde Amendment by immediately filing suit to challenge both the federal law and a New York state statute, neither of which provided funding for medically necessary abortions.[128] Both the Hyde Amendment and the state statute differed starkly from the protections enumerated in *Roe*,[129] which preserved access to medically necessary abortion throughout all three trimesters of pregnancy.[130] The plaintiffs, including pregnant Medicaid enrollees[131] seeking abortions in medically necessary but not life-

[124] *Id.* at 444-45. ("Although serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage, it is hardly inconsistent with the objectives of the Act for a State to refuse to fund unnecessary though perhaps desirable medical services.") *Id.*

[125] *Id.* at 441.

[126] *Id.*

[127] *Id.* at 445.

[128] *See Harris*, 448 U.S. 297 (1980). Unlike some of the other cases discussed in this Article, the plaintiffs in *Harris* challenged *both* the federal law and a New York state statute. *Harris* differs from cases like *Maher* because *Maher* also addressed the issue of nontherapeutic abortions. *See Maher*, 432 U.S. 464 (1977). In contrast, *Harris* only discussed medically necessary abortions. *See Harris*, 448 U.S. 297 (1980).

[129] *Roe*, 410 U.S. at 164-65.

[130] During oral arguments in *Harris*, the Solicitor General conceded that "some . . . women will suffer serious harm" as a result of the funding restrictions, through which they would, in effect, be denied access to abortion. *See* Transcript of Oral Argument, Harris v. McRae, 448 U.S. 297 (1980) (No. 79-1268), https://www.oyez.org/cases/1979/79-1268. *See also Harris*, 448 U.S. at 354 (Stevens, J., dissenting). Indeed, as the Solicitor General acknowledged with commendable candor, the logic of the Court's position would justify a holding that it would be constitutional to deny funding to a medically and financially needy person even if abortion were the only lifesaving medical procedure available.

[131] The named Plaintiff was Cora McRae, a pregnant Medicaid enrollee and New York resident who was in her first trimester of pregnancy at the time the lawsuit was filed. Other plaintiffs included the New York City Health and Hospitals Corp., which operated 16 hospitals, including 12 hospitals that provided abortion services. While the sole named defendant was the Secretary of Health, Education, and Welfare, "the District Court permitted Senators James L. Buckley and Jesse A. Helms and Representative Henry J. Hyde to intervene as defendants." *Harris*, 448 U.S. at 303.

threatening circumstances, filed a class action lawsuit "on behalf of all women similarly situated."[132]

The plaintiffs in *Harris* raised four claims. First, because states were required, under Medicaid, to fund all "necessary medical services,"[133] this required states to fund *all* such services, even if federal funds for a particular service—in this case, abortion—became unavailable because of the Hyde Amendment.[134] Specifically, states could not discriminate[135] against certain medically necessary services "solely on the basis of diagnosis or condition"[136] when making funding determinations.[137] Here, the "diagnosis or condition" was a medically necessary abortion, as determined by a physician.[138] Second, the plaintiffs argued that the Hyde Amendment's funding restrictions impinged upon the "liberty interest" of a pregnant woman to terminate her pregnancy for health reasons, despite the fact that this health exception is protected under the Fifth Amendment Due Process Clause[139] as established in *Roe*.[140]

The plaintiffs' third and fourth claims were grounded in the First Amendment. Specifically, the plaintiffs argued that the Hyde Amendment violated the Establishment Clause because "it incorporates into law the doctrines of the Roman Catholic Church concerning the sinfulness of abortion and the time at which life commences."[141] Also, the plaintiffs alleged that the Hyde Amendment violated the "freedom of religion guaranteed by the Free Exercise Clause" of the First Amendment.[142]

1. Procedural Posture

The United States District Court for the Eastern District of New York[143] granted preliminary injunctive relief to the plaintiffs, pending

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[132] *Harris*, 448 U.S. at 297.

[133] 42 U.S.C. § 1396a.

[134] *Harris*, 448 U.S. at 307.

[135] Plaintiffs argued that "restricting the availability of certain medically necessary abortions under Medicaid, impinges on the 'liberty' [to choose abortion] protected by the Due Process Clause as recognized in *Roe v. Wade*." *Id.* at 312.

[136] 42 U.S.C. § 1396a.

[137] *Harris*, 448 U.S. at 307.

[138] *Id.*

[139] *Id.* at 312.

[140] *Id.* at 315-16. *Roe* represented an expansion of the understanding of "liberty" interests and "fundamental rights" that the Court had previously protected in the realm of "marital privacy." *See supra* note 2, *Skinner*, 316 U.S. at 543, *Griswold*, 381 U.S. at 485-86, *Eisenstadt*, 405 U.S. at 454-55.

[141] *Harris*, 448 U.S. at 319.

[142] *Id.* The Court did not address the merits of this argument: it asserted that the plaintiffs lacked standing to raise this claim.

[143] *See* McRae v. Califano, 491 F. Supp. 630 (E.D.N.Y 1980).

resolution of the matter, "prohibiting the Secretary[144] from enforcing the Hyde Amendment and requiring him to continue to provide federal reimbursement for abortions under the standards applicable before the funding restriction had been enacted."[145] The Secretary appealed.[146] The Supreme Court vacated the District Court's judgment and remanded the case for further consideration in light of *Maher v. Roe*[147] and *Beal v. Doe*,[148] both of which were decided during the 1977 Supreme Court term.[149]

On remand, the District Court permitted several additional plaintiffs to intervene.[150] These included four pregnant Medicaid recipients seeking medically necessary abortions; physicians who performed abortions for Medicaid enrollees; the Women's Division of the Board of Global Ministries of the United Methodist Church (Women's Division); and two officers from the Women's Division.[151]

The District Court held that, while the Hyde Amendment *had* substantively amended the Medicaid Act such that states were no longer obligated to fund medically necessary abortions, the Hyde Amendment "violates the equal protection component of the Fifth Amendment's Due Process Clause and the Free Exercise Clause of the First Amendment."[152] Specifically,

> when an abortion is 'medically necessary to safeguard the pregnant woman's health . . . the disentitlement to Medicaid assistance impinges directly on the woman's right to decide, in consultation with her physician and in reliance on his judgment, to terminate her pregnancy in order to preserve her health.'[153]

The District Court also indicated that the Hyde Amendment "violates the equal protection guarantee because . . . the decision of Congress to fund medically necessary services generally but only certain medically necessary abortions serves no legitimate governmental interest."[154] Therefore, the

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144 Joseph A. Califano, Jr. was the Secretary of Health, Education, and Welfare from 1977-1979.

145 *Harris*, 448 U.S. at 304 ("Although . . . it had not expressly held that the funding restriction was unconstitutional, since the preliminary injunction was not its final judgment, the District Court noted that such a holding was 'implicit' in its decision granting the injunction."). *See also* McRae v. Mathews, 421 F. Supp. 533 (E.D.N.Y. 1976).

146 *Harris*, 448 U.S. at 304.

147 432 U.S. 464 (1977).

148 432 U.S. 438 (1977).

149 *See* Califano v. McRae, 433 U.S. 916 (1977).

150 *Harris*, 448 U.S. at 304.

151 *Id.*

152 *Id.* at 305.

153 *Id.* at 305-06 (*quoting Califano*, 491 F. Supp. at 737).

154 *Harris*, 448 U.S. at 306.

District Court ordered the Secretary to "cease to give effect to the various versions of the Hyde Amendment" and to "continue to authorize the expenditure of federal matching funds for such abortions."[155] The Secretary again appealed to the Supreme Court.[156]

2. Majority Opinion

At the Supreme Court, five Justices rejected each of the plaintiffs' arguments in turn. The Court first addressed the use of Title XIX funds to cover services for which federal funding was no longer available under Hyde[157]—specifically, funding for medically necessary abortions—even though other medically necessary services were still funded.[158] The Court held that the Hyde Amendment had materially altered the Title XIX funding requirements such that states were not required under Medicaid to pay for medical services for which federal funding was unavailable.[159]

The Court spent more time addressing the plaintiffs' second argument, regarding a woman's liberty interest in protecting her health during

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[155] *Id.*

[156] *Id.* The Supreme Court denied the Secretary's application for a stay of the judgment "pending direct appeal of the District Court decision;" however, the Court "noted probable jurisdiction of this appeal." *Id.*

[157] The 1980 version of the Hyde Amendment specified that none of the funds provided by this joint resolution shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest when such rape or incest has been reported promptly to a law enforcement agency or public health service. Pub. L. No. 96-123, § 109, 93 Stat. 923 (1979). Furthermore, this version of the Hyde Amendment is broader than that applicable in fiscal year 1977, which did not include the 'rape or incest' exception . . . but narrower than that applicable for most of fiscal year 1978, and all of fiscal year 1979, which had an additional exception for 'instances where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term when so determined by two physicians,' Pub. L. No. 95-205, § 101, 91 Stat. 1460 (1977); Pub. L. No. 95-480, § 210, 92 Stat. 1586 (1978).
Harris, 448 U.S. at 302-03.

[158] *Id.* at 321-22 (". . . although federal reimbursement is available under Medicaid for medically necessary services
generally, the Hyde Amendment does not permit federal reimbursement of all medically necessary abortions.")

[159] *Id.* at 309. Specifically,

> Title XIX was designed as a cooperative program of shared financial responsibility, not as a device for the Federal Government to compel a State to provide services that Congress itself is unwilling to fund. Thus, if Congress chooses to withdraw federal funding for a particular service, a State is not obliged to continue to pay for that service as a condition of continued federal financial support of other services.

Id. This was consistent with the District Court's ruling on the issue. In fact,
The District Court . . . concluded that, although Title XIX would otherwise have required a participating State to include medically necessary abortions in its Medicaid program, the Hyde Amendment substantively amended Title XIX so as to relieve a State of that obligation.
Id. at 308.

pregnancy.[160] The Court held that the Hyde Amendment did not infringe on this "liberty interest," nor did it threaten the "right to choose" protected in *Roe*,[161] for several reasons.[162] First, the fact that a "health" exception existed under *Roe* did not mean that a woman had a "constitutional entitlement" to government funding in this circumstance.[163] Specifically, the government did not have an "affirmative funding obligation."[164] The Court indicated that

> regardless of whether the freedom of a woman to choose to terminate her pregnancy for health reasons lies at the core or the periphery of the due process liberty recognized in [*Roe v.*] *Wade*,[165] it simply does not follow that a woman's freedom of choice carries with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices.[166]

Furthermore, the Court indicated that the Hyde Amendment did not create any additional obstacles[167] to abortion access.[168] The Court reasoned that the plaintiffs were no worse off than if they had never received any Medicaid funding whatsoever.[169] Specifically, the Hyde Amendment "places no governmental obstacle in the path of a woman who chooses to

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[160] *Id.* at 312. This "liberty interest" is protected under the Fifth Amendment Due Process Clause. *See supra* note 2, *Skinner*, 316 U.S. at 543, *Griswold*, 381 U.S. at 485-86, *Eisenstadt*, 405 U.S. at 454-55.

[161] *See Roe*, 410 U.S 113 (1973).

[162] *Harris*, 448 U.S. at 316.

[163] *Id.* ("It simply does not follow [from Roe] that a woman's freedom of choice carries with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices.")

[164] *Id.* at 318 ("Whether freedom of choice that is constitutionally protected warrants federal subsidization is a question for Congress to answer, not a matter of constitutional entitlement."). However, states participating in Medicaid did have "affirmative funding obligations" to subsidize other necessary medical services. *See* 42 U.S.C. § 1396a.

[165] The Court conceded that "it could be argued that the freedom of a woman to decide whether to terminate her pregnancy for health reasons does in fact lie at the core of the constitutional liberty identified in [*Roe v.*] *Wade*." *Harris*, 448 U.S. at 316.

[166] *Id.*

[167] The "obstacle" at issue was "indigency," a specific term that the Court had previously invoked in its decision in Maher. *See Maher*, 432 U.S. 464 (1977).

[168] *Harris*, 448 U.S. at 316. The Court reached a similar conclusion in *Maher*. *See Maher*, 432 U.S. 464 (1977).

[169] *Harris*, 448 U.S. at 317 ("The Hyde Amendment leaves an indigent woman with at least the same range of choice in deciding whether to obtain a medically necessary abortion as she would have had if Congress had chosen to subsidize no health care costs at all."). The Court circled back to this argument multiple times, both in its Opinion and during questioning at oral arguments—that the government need not fund *any* health services for indigent women, and that, by funding certain services, the government was actively conferring benefits, or "entitlements," upon low-income women. *See Harris*, 448 U.S. at 315-318; *see also*, *Transcript of Oral Argument*, *supra* note 130.

terminate her pregnancy, but rather, by means of unequal subsidization of abortion and other medical services, encourages alternative activity deemed in the public interest."[170]

Additionally, the Court reasoned that "indigent" women seeking medically necessary abortions were neither a "suspect class" warranting strict scrutiny,[171] nor were they deserving of any special protection.[172] The Court indicated that the government did not create the plaintiffs' indigency; therefore, it had no obligation to relieve it.[173] Rather than infringing on a fundamental right, the government simply "encouraged" a different choice—carrying the pregnancy to term—in order to protect potential life.[174]

Finally, the Court held that the Hyde Amendment violated neither the Establishment Clause nor the Free Exercise Clause.[175] While denying federal funding for abortion might intersect with the Catholic Church's tenets, the Court reasoned that this was not the Hyde Amendment's "secular legislative purpose."[176]

After striking down the plaintiffs' arguments regarding the right to equal funding under Title XIX and the Hyde Amendment's infringement on a protected liberty interest, the Court raised a new argument.[177] If the plaintiffs were considered a "suspect class,"[178] the challenged statutes would be subject to strict scrutiny.[179] However, the Court, invoking its previous rationale from *Maher*,[180] indicated that "indigency" was not a suspect classification demanding strict scrutiny.[181] The Court therefore applied the rational basis test and held that "the Hyde Amendment bears a

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[170] *Harris*, 448 U.S. at 315.

[171] Specifically, "this Court has held repeatedly that poverty, standing alone is not a suspect classification." *Id.* at 323.

[172] *Id.* The court suggested that "special protection" would be warranted if the state had caused harm to the individuals.

[173] *Id.*

[174] *Id.* at 324-25 ("Nor is it irrational that Congress has authorized federal reimbursement for medically necessary services generally, but not for certain medically necessary abortions. Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life.").

[175] *Id.* at 319.

[176] *Id.*

[177] *Id*. at 321-23.

[178] The plaintiffs did not allege that they were a "suspect class" for Fifth Amendment purposes. *Id.* at 322-23.

[179] *See Harris*, 448 U.S. at 322 ("The guarantee of equal protection under the Fifth Amendment is not a source of substantive rights or liberties, but rather a right to be free from invidious discrimination in statutory classifications and other governmental activities.").

[180] *See Maher*, 432 U.S. 464 (1977).

[181] *Harris*, 448 U.S. at 324.

rational relationship to [the State's] legitimate interest in protecting the potential life of the fetus" and therefore held that both the Hyde Amendment and the New York state statute should be upheld.[182]

3. Dissenting Opinions

Four Justices dissented in *Harris*,[183] leaving the plaintiffs just one vote shy of ensuring that the protections enshrined in *Roe* would be available for *all* women, including low-income women. It is therefore worth exploring the four dissenting Justices' reasoning in some detail.

Justice Brennan stated that the Court's majority opinion was a "mischaracterization of the nature of the fundamental right recognized in *Roe*."[184] He argued that *every* pregnancy is a procedure "requiring medical services"—the question is just whether the required service is prenatal care or an abortion.[185] Specifically, "in every pregnancy, one of these two courses of treatment is medically necessary, and the poverty-stricken woman depends on the Medicaid Act to pay for the expenses associated with the procedure."[186] Furthermore, by

injecting coercive financial incentives favoring childbirth into a decision that is constitutionally guaranteed to be free from government intrusion, the Hyde Amendment deprives the indigent woman of her freedom to choose abortion over maternity, thereby impinging on the due process liberty right recognized in *Roe v. Wade*.[187]

Justice Brennan highlighted the "unequal subsidization of abortion and childbirth"[188] and characterized this as "unconstitutionally burden[ing] fundamental rights."[189] He asserted that, "by funding all of the expenses associated with childbirth and none of the expenses incurred in terminating pregnancy, the government literally makes an offer that the indigent woman cannot afford to refuse."[190] Justice Brennan further postulated that, had the government offered to equally subsidize abortion and prenatal services, or

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[182] *Id.*

[183] There were four separate dissenting opinions in *Harris v. McRae*: Justice Brennan, with whom Justice Marshall and Justice Blackmun joined; Justice Marshall; Justice Blackmun; and Justice Stevens. *Id.* at 329-57.

[184] *Id.* at 329 (Brennan, J., dissenting).

[185] *Id.* at 331-32 ("Pregnancy is unquestionably a condition requiring medical services . . . Treatment for the condition may involve medical procedures for its termination, or medical procedures to bring the pregnancy to term, resulting in a live birth.").

[186] *Id.* at 333.

[187] *Id.*

[188] *Id.*

[189] *Id.* at 335-36.

[190] *Id.* at 333-34.

had it refused to subsidize *either* type of service, "many poverty-stricken women . . . would have chosen to have an abortion" instead.[191] Justice Brennan explained that "the government withholds financial benefits in a manner that discourages the exercise of a due process liberty"[192] and that "[t]he indigent woman who chooses to assert her constitutional right to have an abortion can do so only on pain of sacrificing health-care benefits to which she would otherwise be entitled."[193]

Justice Marshall focused much of his opinion on the negative health consequences that would almost certainly result from the government's refusal to subsidize abortion for low-income women. He stated that "the Court's opinion studiously avoids recognizing the undeniable fact that for women eligible for Medicaid—poor women—denial of a Medicaid-funded abortion is equivalent to denial of legal abortion altogether"[194] because Medicaid enrollees by definition cannot afford to pay for an abortion, or any other medical care, without public assistance.[195] Furthermore, "the predictable result of the Hyde Amendment will be a significant increase in the number of poor women who will die or suffer significant health damage because of an inability to procure necessary medical services."[196] Justice Marshall emphasized that "[f]ederal funding is thus unavailable even when severe and long-lasting health damage to the mother is a virtual certainty."[197] Furthermore, "[n]or are federal funds available when severe health damage, or even death, will result to the fetus if it is carried to term."[198]

Justice Marshall thoroughly detailed the types of dire medical implications that the Hyde Amendment foisted upon low-income women. Specifically,

> numerous conditions—such as cancer, rheumatic fever, diabetes, malnutrition, phlebitis, sickle cell anemia, and heart disease—substantially

[191] *Id.* at 334 ("[T]he discriminatory distribution of the benefits of governmental largesse can discourage the exercise of fundamental liberties just as effectively as can an outright denial of those rights." Furthermore, "implicit in the Court's reasoning is the notion that as long as the Government is not obligated to provide its citizens with certain benefits or privileges, it may condition the grant of such benefits on the recipient's relinquishment of his constitutional rights.").

[192] *Id.* at 336.

[193] *Id.*

[194] *Id.* at 338 (Marshall, J., dissenting).

[195] *Id.*

[196] *Id.*

[197] *Id.* at 339.

[198] *Id.* Justice Marshall further notes, citing the record from the District Court decision, that "in States that have adopted a standard more restrictive than the 'medically necessary' test of the Medicaid Act, the number of funded abortions has decreased by over 98%." *Id.*

> increase the risks associated with pregnancy or are themselves aggravated by pregnancy. Such conditions may make an abortion medically necessary in the judgment of a physician, but cannot be funded under the Hyde Amendment. Further, the health risks of undergoing an abortion increase dramatically as pregnancy becomes more advanced. By the time a pregnancy has progressed to the point where a physician is able to certify that it endangers the life of the mother, it is in many cases too late to prevent her death because abortion is no longer safe. There are also instances in which a woman's life will not be immediately threatened by carrying the pregnancy to term, but aggravation of another medical condition will significantly shorten her life expectancy. These cases as well are not fundable under the Hyde Amendment.[199]

Justice Marshall also cited the negative mental health consequences of an unwanted pregnancy, which could lead to suicide.[200] In addition, he indicated that federal funding was also not available for abortion in cases in which the fetus would not survive, which he found odd, considering the Majority's—and the government's—emphasis on "normal childbirth."[201] In addition, Justice Marshall noted that the rapid reporting requirement for pregnancies caused by rape or incest in order to qualify for funding under the Hyde Amendment can be "especially burdensome for the indigent" and may "exclude those who are afraid of recounting what has happened" or those who "are in fear of unsympathetic treatment by the authorities."[202]

Justice Marshall suggested that "the Constitution requires a more exacting standard of review than mere rationality in cases such as this one."[203] Justice Marshall repeatedly compared his dissenting opinion in this case to his dissent in *Maher v. Roe*.[204] However, he took issue with the fact that the Court "treats this case as though it were controlled by *Maher*" when, to the contrary, "this case is the mirror image of *Maher*."[205] Justice Marshall explained that, in *Maher*, the Court's reasoning for denying abortion coverage for indigent women turned on the fact that the abortions were nontherapeutic—that is, not medically necessary—and Medicaid funding was only available for medically-necessary procedures.[206]

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[199] *Id.* at 339-40.

[200] *Id.* at 340.

[201] *Id.*

[202] *Id.*

[203] *Id.* at 341("While it is now clear that traditional 'strict scrutiny' is unavailable to protect the poor against classifications that disfavor them . . . I do not believe that legislation that imposes a crushing burden on indigent women can be treated with the same deference given to legislation distinguishing among business interests.") *Id.* at 342.

[204] *Id.* at 343.

[205] *Id.* at 345.

[206] *Id.*

Therefore, the *Maher* plaintiffs were seeking access to "benefits which were not available to others similarly situated."[207] In contrast, the *Harris* plaintiffs in this case "are protesting their exclusion from a benefit that is available to all others similarly situated"—specifically, other indigent women enrolled in Medicaid seeking coverage for medically-necessary services and procedures.[208]

Justice Marshall argued that "the interest asserted by the government, the protection of fetal life, has been declared constitutionally subordinate to appellees' [plaintiffs'] interest in preserving their lives and health by obtaining medically necessary treatment [in] *Roe v. Wade*."[209] He also voiced his concern that the expressed purpose of the Hyde Amendment "was to discourage the exercise of [a] fundamental right"—the right to access abortion.[210]

Justice Blackmun filed a brief dissent, in which he cited his dissenting opinions from *Beal v. Doe*[211] and *Maher v. Roe*[212] and indicated that "there is condescension in the Court's holding that '[the plaintiff] may go elsewhere for her abortion.'"[213] He further stated that the Court's reasoning was "disingenuous and alarming."[214] Justice Blackmun also argued that, as a result of the Court's ruling, the "cancer of poverty will continue to grow."[215]

Justice Stevens,[216] like Justice Marshall, differentiated *Harris* from *Maher*, stating that, in *Harris*, the plaintiffs satisfied "two neutral statutory criteria—financial need and medical need" for access to Medicaid services, whereas the *Maher* plaintiffs, who were seeking nontherapeutic (not medically necessary) abortions, did not satisfy the "medical need" criterion.[217] Justice Stevens argued that the Court "shirks [its] duty" to

[207] *Id.*

[208] *Id.*

[209] *Id.* at 346.

[210] *Id.* Furthermore, "the Court perceives this result as simply a distinction between [a] 'limitation on government power' and 'an affirmative funding obligation' . . . for a poor person attempting to exercise her 'right' to freedom of choice, the difference is imperceptible." *Id.* at 347.

[211] *Beal*, 432 U.S. 438 (1977).

[212] *Maher*, 432 U.S. 464 (1977).

[213] *Id.* at 348 (Blackmun, J., dissenting).

[214] *Id.*

[215] *Id.* at 349.

[216] "The competing interests [here] are the interest in maternal health and the interest in protecting potential human life. It is now part of our law that the pregnant woman's decision as to which of these conflicting interests shall prevail is entitled to constitutional protection." *Id.* at 350 (Stevens, J., dissenting).

[217] *Id.* at 349-50 ("Nontherapeutic abortions were simply outside the ambit of [Medicaid's] medical benefits program.").

respect the holding of *Roe*, which protected access to abortion, in all three trimesters, where necessary to preserve maternal *health*, and the Court "totally fails to explain why this reasoning [in *Roe*] is not dispositive here."[218] Justice Stevens indicated that this "denial of benefits for medically necessary abortions . . . is tantamount to severe punishment" and that "cannot be justified unless the government may . . . punish women who want abortions. But as the Court unequivocally held in *Roe v. Wade*, this the government may not do."[219] Justice Stevens also highlighted the irony that the cost of an abortion is actually much *less* than the costs associated with childbirth, and yet the government would rather spend *more* money to discourage women from exercising a particular constitutionally-protected choice.[220]

F. Planned Parenthood v. Casey

Twelve years after the Court decided *Harris v. McRae*, in *Planned Parenthood v. Casey* ("*Casey*"), the Supreme Court established the more restrictive "undue burden" standard for women seeking access to abortion.[221] Furthermore, the Court evaluated the concept of a woman's "reliance interest"[222] in the continued availability of abortion following *Roe*.[223] The plaintiffs in *Casey* challenged the constitutionality of five provisions of Pennsylvania's Abortion Control Act.[224] Four of these

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[218] *Id.* at 351-52. Specifically,

> *Roe v. Wade* squarely held that the States may not protect that interest when a conflict with the interest in a pregnant woman's health exists. It is thus perfectly clear that neither the Federal Government nor the States may exclude a woman from medical benefits to which she would otherwise be entitled solely to further an interest in potential life when a physician, "in appropriate medical judgment," certifies that an abortion is necessary "for the preservation of the life or health of the mother." *Roe v. Wade*, *supra*, at 165 . . . the Court totally fails to explain why this reasoning is not dispositive here.

Id. at 352.

[219] *Id.* at 355.

[220] *Id.* Furthermore,

> The Hyde Amendments not only exclude financially and medically needy persons from the pool of benefits for a constitutionally insufficient reason; they also require the expenditure of millions and millions of dollars in order to thwart the exercise of a constitutional right, thereby effectively inflicting serious and long-lasting harm on impoverished women who want and need abortions for valid medical reasons.

Id. at 356.

[221] *See Casey*, 505 U.S. at 837.

[222] *Id.* at 855 ("The inquiry into reliance counts the cost of a rule's repudiation as it would fall on those who have relied reasonably on the rule's continued application.").

[223] *Id.* at 856.

[224] *Id.* at 833. The five provisions (1) required that the pregnant woman provide informed consent before the procedure and that the clinic provide her with "certain information" twenty-four hours before

provisions were upheld under the "undue burden" standard: specifically, the requirements imposed upon a woman before she could obtain an abortion were not so difficult—not so *burdensome*—that they would violate *Roe*'s protection for a woman's right to choose.[225] A provision places an undue burden on a pregnant woman's ability to access abortion—and would therefore be invalidated—if it creates a "substantial obstacle" to access.[226]

The Court in *Casey* also considered whether its decision in *Roe* should be overturned completely.[227] The Court determined that, following the principle of *stare decisis*, *Roe* should be reaffirmed.[228] The Court indicated that, since *Roe*, many women had made choices—and even structured their lives—around the assumption that abortion would be available in the event of an unplanned pregnancy.[229] Specifically, women had developed a "reliance interest" in the continued availability of abortion.[230] The Court rejected the argument that there can be no reliance interest for something that is by nature unplanned—in this case, an unplanned pregnancy.[231] The Court reasoned that women still plan their lives around the availability of reproductive health services, even if they do not know for certain that they will eventually need to use them.[232] While the Court noted that the exact level of reliance on access to abortion would be difficult to measure, it would be dangerous to extrapolate that women rely so little on access to abortion that the Court could justify banning it completely.[233]

the procedure; (2) required that minors obtain informed consent from one parent but also provided for a judicial bypass procedure in instances where parental consent was impossible; (3) required "spousal notification," meaning that the pregnant woman needed to sign a statement indicating that she had notified her husband; (4) defined "medical emergency" to identify situations in which these requirements could be disregarded; and (5) imposed reporting requirements on abortion providers. *Id.*

[225] *Id.* at 874. The spousal consent requirement was struck down because it was determined to be an "undue burden" on the pregnant woman that hindered her ability to obtain an abortion. *Id.*

[226] *Id.* at 837 ("An undue burden exists . . . if its purpose or effect is to place substantial obstacles in the path of a woman seeking an abortion before the fetus attains viability.").

[227] *Id.* at 846.

[228] *Id.*

[229] *Id.* at 856 ("For two decades of economic and social developments, people organized intimate relationships and made choices that defined their views of themselves and their places in society in reliance on the availability of abortion.").

[230] *Id.*

[231] *Id.*

[232] *Id.*

[233] *Id.*

G. Current Landscape of Abortion Access

One in four women will have an abortion in her lifetime.[234] Approximately 862,320 abortions were provided in U.S. clinics[235] in 2017,[236] representing a 7 percent decrease since 2014 "and the continuation of a long-term trend" in declining abortion rates.[237] In 2017, the U.S. abortion rate was approximately 13.5 abortions per 1000 women between the ages of 15 and 44, "the lowest rate recorded since abortion was legalized in 1973."[238] Regional disparities in abortion access have been exacerbated in recent years: while the number of clinics has increased in the Northeast and the West over the past few years, the number of clinics has decreased in the Midwest and the South.[239]

III. ANALYSIS

The many unsuccessful legal challenges raised against both the Hyde Amendment and similar anti-choice state statutes, as well as increasing regional disparities in abortion access, paint a bleak picture of the landscape of women's reproductive health. For low-income women seeking to protect the basic right to preserve their health, access to abortion is severely limited in many states.[240] In *Roe*, the Court protected the right to a medically necessary abortion throughout all three trimesters of pregnancy.[241] Following *Roe*, women across the United States began to assume that they would be able to obtain abortions if their health were in danger during pregnancy. Many sexually active women relied on the availability of abortion if contraception failed and if the subsequent pregnancy jeopardized their health.[242] Low-income women relying on Medicaid for health care services in a post-*Roe* world reasonably assumed that this right was not

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[234] RACHEL K. JONES ET AL., ABORTION INCIDENCE AND SERVICE AVAILABILITY IN THE UNITED STATES, 2017 (2019), https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017.

[235] Approximately 95 percent of abortions during this period were performed in clinics, versus just 5 percent in hospitals or physicians' offices. *Id.*

[236] The Guttmacher Institute's most recent abortion statistics are from 2017, from its Abortion Provider Census ("APC"). This particular study analyzed data from the period from 2014 through 2017.

[237] *Id.*

[238] *Id.*

[239] *Id.* Specifically, between 2014 and 2017, "the number of clinics increased in the Northeast and the West, by 16% and 4% respectively, and decreased in the Midwest and the South, by 6% and 9%, respectively." *Id.*

[240] *See* notes 234-39.

[241] *See Roe*, 410 U.S. 113 (1973).

[242] *See Casey*, 505 U.S. 833 (1992).

contingent upon socioeconomic status.[243] Many women planned their lives around this expectation.[244]

The Hyde Amendment radically altered the landscape for Medicaid enrollees seeking abortions, especially women seeking medically necessary abortions, by rescinding previously available funding.[245] This all but barred low-income women from accessing abortion, which could be prohibitively expensive without public subsidies.[246]

Ana[247] happened to live in Pennsylvania,[248] a state with strict anti-choice laws at the time.[249] These include a 24-hour waiting period between the initial appointment and the procedure, mandatory counseling intended to discourage the pregnant woman from obtaining an abortion, and a parental consent requirement for minors[250] such as herself. Furthermore, public funding is only available in cases of life endangerment, rape, or incest.[251] Ana relied—to her detriment—on the assumption that a medically necessary abortion at Planned Parenthood would be covered under Medicaid. Ana, like many low-income women similarly situated, had detrimentally relied[252] on public funding that *was* available before the Hyde Amendment was implemented, as well as on a funding structure that *does* cover other medically necessary services.[253]

Between the Supreme Court's decision in *Roe* and the implementation of the Hyde Amendment, women like Ana relied on federal subsidies for reproductive health services—including abortion—to preserve their health.[254] Upon discovering that she was pregnant, Ana faced a terrible

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[243] *See* Jones et al., *supra* note 69, 23 WOMEN'S HEALTH ISSUES at 173-78.

[244] *See Casey*, 505 U.S. 833 (1992).

[245] *See supra* note 8.

[246] *See* Jones et al., *supra* note 69, 23 WOMEN'S HEALTH ISSUES at 173-78.

[247] *See supra* Part I for a discussion about Ana, a young woman from Philadelphia who the author met during a summer internship at Planned Parenthood.

[248] STATE FACTS ABOUT ABORTION: PENNSYLVANIA (2021), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-pennsylvania. These are the restrictions in effect as of September 1, 2020.

[249] In 2017, 43 facilities provided abortions in Pennsylvania, 18 of which were clinics. *Id.* This represents an overall 10 percent decrease since 2014, when there were 20 clinics in Pennsylvania that provided abortions. *Id.* In 2017, approximately 85 percent of Pennsylvania counties did not have a single abortion provider, and approximately 48 percent of Pennsylvania women lived in counties without a single abortion provider. *Id.*

[250] *Id.*

[251] *Id.*

[252] Detrimental reliance, as the Court suggested in *Casey*, is comprised of (1) a representation, (2) reliance, and (3) a detrimental change in position as a result of this reliance. *See Casey*, 505 U.S. at 846.

[253] *See* 42 U.S.C. § 1396a.

[254] Nationwide, childbirth is fourteen times more likely than abortion to lead to death. *See Whole Woman's Health*, 136 S. Ct. at 2315.

choice: she could either jeopardize her health by carrying the pregnancy to term,[255] despite her physician's recommendation that she terminate the pregnancy, or she could struggle to acquire enough money for the procedure,[256] because the government refused to subsidize it.[257]

Following *Roe*, both the federal government and state governments took actions that would lead a reasonable person to believe that medically necessary abortions would be subsidized for low-income women.[258] First, both federal funds and state Medicaid dollars were used to finance abortions.[259] Second, state welfare funds were used to subsidize abortions.[260] Third, even though abortion was not mentioned in the Medicaid Act, the statutory language explicitly required states to cover both "all medically necessary services" and "family planning services."[261] Medically necessary abortions fit both of these criteria.[262]

In *Maher*, the Court suggested that low-income women relying on Connecticut's public assistance program were no worse off than they were before Medicaid was available.[263] Before the plaintiffs challenged the statute, low-income women had relied on private funding for abortions: following the Court's decision, Connecticut women were once again expected to rely on this funding.[264] *Maher* is distinct from *Harris* because in *Maher*, the low-income women were seeking nontherapeutic (elective) abortions, for which they relied on private funds.[265] In *Harris*, the affected plaintiffs were actively relying on federal funding for *medically necessary* abortions when this funding suddenly became unavailable upon implementation of the Hyde Amendment.[266]

As the Court indicated in *Casey*, after abortion was legalized under *Roe*, many women began to plan their lives around the assumption that, if

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[255] *See Simat*, 203 Ariz. 454 (2002). While the author is not sure whether Ana considered a self-induced abortion, this dangerous practice is, unfortunately, all too common. *See supra* note 234. In fact, in 2017, 18 percent of clinics surveyed by the Guttmacher Institute responded that they had provided care to at least one woman who attempted to self-abort, up from 12 percent of clinics surveyed in 2014. *Id.*

[256] *See* Jones et al., *supra* note 69, 23 WOMEN'S HEALTH ISSUES at 173-78.

[257] *See supra* note 8.

[258] *See Roe*, 410 U.S. 113 (1973).

[259] *See Califano*, 491 F. Supp. at 634.

[260] *See supra* notes 107-10.

[261] 42 U.S.C. § 1396a.

[262] The Title X Family Planning Program was also implemented by the Nixon Administration between passage of the Medicaid Act and *Roe*. *See supra* note 31, Pub. L. No. 91-572 (1970).

[263] *See Maher*, 432 U.S. at 474.

[264] *Id.*

[265] *Id.*

[266] *See Harris*, 448 U.S. 297 (1980).

they should face unplanned pregnancies, they would have the option to terminate.[267] They developed a "reliance interest" on the availability of abortion.[268] When abortion funding was taken away from low-income women who relied on government subsidies for medically necessary services, women were thereby irreparably harmed.

As the four dissenting Justices noted in *Harris*,[269] the Medicaid program provides public funding for medically necessary services for its low-income enrollees. It is this one notable procedure—abortion—that is excluded from federal funding, even when the procedure is deemed medically necessary by a physician, and even when carrying the pregnancy to term will result in severe, long-term physical or mental health damage to the mother.[270] The Court's majority opinion fails to address the glaring lack of a "health of the mother" exception to the Hyde Amendment, despite the fact that the mother's health is explicitly protected throughout all three trimesters of pregnancy in *Roe*.[271] As Justice Stevens bluntly noted in his dissenting opinion, "the Court totally fails to explain why this reasoning is not dispositive here."[272]

The Court in *Harris* erred in upholding the Hyde Amendment, despite vigorous dissents by four Justices, as did later sessions of Congress, in which members reauthorized the flawed legislation several times.[273] The Hyde Amendment fails to allot funding for medically necessary abortions,[274] even though (1) this medically necessary procedure is legally protected under *Roe*,[275] (2) Medicaid covers all "medically necessary services,"[276] and (3) low-income women who rely on Medicaid for all other health services are unlikely be able to afford an abortion without federal subsidies.[277] Medicaid recipients have detrimentally relied[278] on the availability of these funds. To yank them away would violate the "reliance interest" concept enumerated in *Casey*: specifically, that many women have structured their lives around the assumption that abortion would remain

[267] *See Casey*, 505 U.S. at 846.

[268] *Id*.

[269] *Harris*, 448 U.S. at 329-57 (Justices Brennan, Marshall, Blackmun, and Stevens dissented).

[270] *See Harris*, 448 U.S. at 339.

[271] *See Roe*, 410 U.S. 113 (1973).

[272] *Harris*, 448 U.S. at 350.

[273] *See* H.R. 7, 115th Cong.

[274] *See supra* note 8.

[275] *See Roe*, 410 U.S. 113 (1973).

[276] 42 U.S.C. § 1396a.

[277] *See* Jones et al., *supra* note 69, 23 WOMEN'S HEALTH ISSUES at 173-78.

[278] *See Casey*, 505 U.S. at 846.

accessible and, for Medicaid recipients, that it would remain affordable.[279] It is time to revisit the majority's flawed reasoning in *Harris* and finally overturn the Hyde Amendment.

IV. CONCLUSION

We now face a time when the concepts of "health" and "health care" are particularly salient.[280] Yet, the controversy surrounding the Hyde Amendment stems from several hotly contested political issues: abortion, health care, and Medicaid. Highly partisan views are based on radically different opinions and assumptions about low-income women, poverty, and welfare. This controversy has caused support for or opposition to the Hyde Amendment to become a political litmus test. However, the Hyde Amendment ultimately turns on the issue of women's equality. Specifically, how much freedom and control women should have over their bodies, and whether all women, regardless of socioeconomic status, should enjoy the same freedoms. Higher income women will find ways to finance abortions and thereby control their fertility—and control their own lives. Unfortunately, for low-income women who rely on government assistance to help them exercise control over their bodies, they have been repeatedly hurt by partisan attempts to curtail reproductive rights.

The Hyde Amendment set the United States back in its march toward women's equality by denying funding to low-income women for one particularly controversial, but nonetheless *medically necessary*, procedure. The government continues to demonize women for attempting to exercise a legally protected right.

The Hyde Amendment denies federal funding for abortion for low-income women in contravention of *Roe*,[281] which protected medically necessary abortions in all three trimesters of pregnancy. It also conflicts with *Casey*, in which the Court indicated that it would be a violation of *Roe* to rescind the reproductive rights and protections upon which women had come to rely.[282] The Hyde Amendment is a dangerous piece of legislation that flagrantly jeopardizes women's health, and it should be exposed for the anti-woman agenda underlying it. The Court in *Harris* erred in upholding it, subsequent sessions of Congress have erred by reauthorizing it, and it is time to overturn it.

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279 *See* Jones et al., *supra* note 69, 23 WOMEN'S HEALTH ISSUES at 173-78.

280 This Article was completed in the fall of 2020, during the height of the COVID-19 crisis.

281 *See Roe*, 410 U.S. 113 (1973).

282 *See Casey* at 855-56.