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TAX-SUPPORTED ABORTIONS: THE LEGAL ISSUES

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The tradition of the United States Supreme Court in the immediate aftermath of its many so-called "landmark" decisions has manifested itself in two mutually exclusive patterns. Either the landmark decision has indicated the high water mark of a particular legal theory or in the alternative, the decision has proven to be the jumping-off point for its further extension. With respect to the Supreme Court's companion abortion decisions of 1973,[1] the course of further development is not, as yet, completely clear. Nevertheless, some indications are apparent.

While most anti-abortion forces have concentrated on the rather nebulous goal of implementing a constitutional Right-to-Life amendment, other agencies have continued to concentrate on the courts in an attempt to keep the impact of these abortion decisions within the narrowest possible confines. The success of these efforts, to date, has been only slightly encouraging. Publicly owned hospitals have been obligated to provide abortion and sterilization services.[2] Many private hospitals are being pressured into abandoning their anti-abortion positions[3] and have opened their doors to these procedures. Even religiously affiliated hospitals have been subjected to legal attack and are currently engaged in several lawsuits to defend their right to stand for life.[4]

Perhaps the most meaningful legal battle being waged is the one over

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[1] Roe v. Wade, 410 U.S. 113 (1973); Doe v. Bolton, 410 U.S. 179 (1973).

[2] Doe v. Hale Hosp., 500 F.2d 144 (1st Cir. 1974); Doe v. Poelker, 497 F.2d 1063 (8th Cir. 1974); Word v. Poelker, 495 F.2d 1349 (8th Cir. 1974); Hathway v. Worcester City Hosp., 475 F.2d 701 (1st Cir. 1973); Doe v. Mundy, 378 F. Supp. 731 (E.D. Wis. 1974).

[3] On July 12, 1974, the Women's Rights Project, American Civil Liberties Union, 22 East 40th Street, New York, N.Y. 10016, released a memorandum with attached model complaints and affidavits, entitled: "Lawsuits Against Private Hospitals Which Refuse to Perform/Permit Abortions."

[4] 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); Portman v. Suburban Hosp., No. B-74-591 (D. Md., Jan. 6, 1975); Taylor v. St. Vincent's Hosp., 369 F. Supp. 948 (D. Mont. 1973); Watkins v. Mercy Medical Center, 364 F. Supp. 799 (D. Idaho 1973); Allen v. Sisters of St. Joseph, 361 F. Supp. 1212 (N.D. Tex. 1973), *dismissed as moot per curiam*, 490 F.2d 81 (5th Cir. 1974); Ham v. Holy Rosary Hosp., 529 P.2d 361 (Mont. Sup. Ct. 1974); Simon v. Holy Cross Hosp., Eq. No. 50,440 (Montgomery County Cir. Ct. Md., pending).

the question of who is to pay for abortions and sterilizations. During the 1973-1974 fiscal year, an estimated $50,000,000 in federal tax money was used to provide more than 250,000 abortions.[5] Additional funding for these services was provided through state and local welfare programs.[6] The coming of national health insurance can only magnify these figures as coverage is extended beyond today's more limited welfare recipient categories.[7]

The pro-abortion forces have used an array of legal devices within the court system in order to open up more and more channels of "free" access to abortion. Not only must abortion be decriminalized,[8] but, if necessary, every available element within our society must be coerced to contribute to or assist in the provision of these services. The presence of a religious hospital evidencing concern for life is anathema to these people. Doctors and nurses, who have been trained in federally financed facilities, may not be permitted to refuse them.[9] Their own neoreligion of nonlife must be supported by the government as primary. The particular legal arguments

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[5] Dr. Louis Hellman, Deputy Assistant Secretary for Population Affairs, Department of Health, Education, and Welfare (HEW), has estimated that Medicaid spent $40 to $50 million on between 222,000 and 278,000 abortions during the Government's fiscal year 1973. This amount constituted 90% of the cost of such abortions pursuant to the provisions of 42 U.S.C. § 1396(a)(5) (Supp. III, 1973), which authorizes such percentage of federal copayment for "family planning services and supplies."

Under new HEW regulations, 39 Fed. Reg. 42,919 (1974), the Department has indicated that it will no longer treat abortion as family planning but as a general medical-surgical service, thus reducing the federal contribution to a 50% level. Various pro-abortion organizations have announced their intent to challenge this change in the courts.

[6] Several federal courts, both at the district and the appellate levels, have ordered state and local welfare offices to fund abortion services for the various assistance groups. *See* Wulff v. Singleton, 508 F.2d 1211 (8th Cir. 1975); Doe v. Wohlgemuth, 505 F.2d 186 (2d Cir. 1974); Doe v. Rose, 499 F.2d 112 (10th Cir. 1974); Roe. v. Ferguson, ___ F. Supp. ___ (S.D. Ohio 1974); Doe v. Ceci, 384 F. Supp. 7 (E.D. Wis. 1974); Doe v. Westby, 383 F. Supp. 1143 (D.S.D. 1974); Roe v. Norton, 380 F. Supp. 726 (D. Conn. 1974).

[7] All the leading national health insurance bills introduced into the 94th Congress anticipate a "universal" program of coverage for every American citizen and every resident of the United States.

[8] The declaratory relief sought by the plaintiffs in Roe v. Wade, 314 F. Supp. 1217 (N.D. Tex. 1970), *modified*, 410 U.S. 113 (1973), was to have a determination made of the constitutionality of the Texas criminal abortion statute and to enjoin this enforcement as against the plaintiff and her physician. Similar action was sought in Doe v. Bolton, 319 F. Supp. 1048 (W.D. Ga. 1970), *aff'd as modified*, 410 U.S. 179 (1973), as to the modified Georgia criminal code. GA. CODE ANN. §§ 26-1201—03 (1968), *as amended*, GA. CODE ANN. §§ 26-1201—04 (Supp. 1974).

[9] Bills have been introduced into the state legislatures of Oregon, Florida, and Wisconsin which would have the effect of limiting the licenses of physicians, nurses, and other health personnel who repeatedly fail to respond to requests for abortion services. In Wisconsin, bills were introduced into the 1973 legislature which would have defined "immoral and unprofessional" conduct in the practice of medicine to include "refusing, on grounds of religious belief, morality or ethics, to perform an operation to remove a human embryo or human fetus from any person . . . ." Wis. A. 58 (1973). Violation of this provision would have required the permanent revocation of the medical license.

advanced by these abortion proponents rely on three concepts: due process, equal protection, and statutory claims to abortion.

DUE PROCESS

An argument, periodically raised, but never fully supported by the courts, has been that individuals may assert a right to implementation of constitutional rights, a right to have rights, so to speak. This basic argument would hold, absent any other conditions, that the federal government can require the states to not only not prohibit abortions, but to affirmatively promote them to the extent of paying for the services on a universal basis. Unfortunately, this argument, while tenuous, need not be fully invoked by the pro-abortionists. All fifty states now participate in the federal-state Medicaid program.[10] Thus, government has already initiated the possibility of a condition which may be utilized to wedge open the door to governmental payment for abortions. A long series of Supreme Court decisions has already cleared the way for this argument: a state may not condition statutory entitlements upon forfeiture of constitutional rights.[11]

Pro-abortionists argue that the Medicaid program pays for medical-surgical procedures which are necessary for the health and physical well-being of eligible participants. If the state was to limit an individual's participation in the program relative to abortion, it would be conditioning the receipt of this statutory benefit upon the forfeiture of the patient's newly established constitutional right to have an abortion. Thus, the "Catch-22" of constitutional law has been invoked.[12]

The one major presupposition of the pro-abortionist in this argument is that the Supreme Court has raised abortion to the level of a positive constitutional right. While there are many things that can be said about the January 22, 1973 decisions, *Roe v. Wade*[13] and *Doe v. Bolton*,[14] the one thing that can never be admitted is that the Court did anything more than decriminalize a theretofore forbidden act and set up limitations beyond which the state could not interfere. There is neither a reference nor even a suggestion that the state would now be obligated to embark on a positive program to implement abortion.[15]

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[10] Arizona, the last holdout, will officially begin participation in the program October 1, 1975. ARIZ. REV. STAT. ANN. § 11-291 *et. seq.* (Supp. 1974).

[11] Sherbert v. Verner, 374 U.S. 398 (1963) (unemployment compensation); Slochower v. Board of Educ. 350 U.S. 551 (1956) (public employment); Speiser v. Randall, 357 U.S. 513 (1958) (tax exemption).

[12] In Shapiro v. Thompson, 394 U.S. 618 (1969), the Supreme Court invalidated state residency requirements as a pre-condition for the receipt of welfare benefits. Procedural requirements could not be used to unconstitutionally burden the poor from moving interstate.

[13] 410 U.S. 113 (1973).

[14] *Id.* at 179.

[15] The "right to privacy," which the Supreme Court has now said includes the right of a pregnant woman to choose abortion in consultation with her physician had been enunciated

One possible door is left open to the individual states in this respect. The question of abortion-on-demand versus abortion-for-medical-necessity may be legitimately raised. Most state Medicaid regulations provide that payment will be made only for "medically necessary" procedures, and nearly all private commercial health insurers and Blue Cross/Blue Shield have a similar restriction. Thus, such items as noncongenital cosmetic surgery, experimental surgery, breast augmentations, etc., are not reimbursable under these payment programs. In *Klein v. Nassau County Medical Center*,[16] a federal district court invalidated a New York State Medicaid requirement which limited reimbursement to "medically necessary" procedures. On appeal to the Supreme Court, the case was remanded in a per curiam decision for reconsideration by the lower court.[17] Apparently, all that the state could demand would be a "bare assertion" by the treating physician that the procedure was medically necessary: small comfort to those as yet unborn children, but, nevertheless, not an entirely "green light" to pro-abortionists.

EQUAL PROTECTION

A much more formidable and, so far, effective pro-abortion argument has been the contention that the exclusion of abortion and sterilization benefits from Medicaid results in the creation of two classes of welfare recipients: those seeking abortions or sterilizations and those seeking other medical-surgical procedures of similar complexity, including, most importantly, the obstetrical delivery itself.[18] Assuming the state has some sort of positive obligation to assist in obtaining abortions, this equal protection argument may require that the state treat both categories the same. If benefits are to be denied, the state must first show a compelling state interest superceding the right of the patient. As a practical matter, such an interest would be almost impossible to construct and would immediately subject the state to the *Roe v. Wade* holding of non-state interference.[19]

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by the Court in other cases involving socially ambivalent behavior. *See* Eisenstadt v. Baird, 405 U.S. 438 (1972) (artificial contraception in the unmarried relationship); Stanley v. Georgia, 394 U.S. 557 (1969) (possession of pornography in the home for personal use); Griswold v. Connecticut, 381 U.S. 479 (1965) (birth control in the marriage relationship).

[16] 347 F. Supp. 496 (E.D.N.Y. 1972), *vacated*, 412 U.S. 925 (1973).

[17] 412 U.S. 925 (1973).

[18] In Doe v. Wohlgemuth, 376 F. Supp. 173 (W.D. Pa. 1974), *vacated*, 505 F.2d 186 (2d Cir. 1974), a special three-judge federal panel had held that once a state had chosen to pay for medical services rendered in connection with the pregnancies of some indigent women, *i.e.*, the actual obstetrical delivery, it could not thereafter refuse to pay for voluntary nontherapeutic abortions in connection with the pregnancies of other indigent women.

[19] [T]he 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

In addition to the argument that exclusion of abortion from Medicaid results in the creation of two classes of welfare recipients, a less effective argument raised by the pro-abortion forces has been that the state's refusal to pay for abortions results in an unconstitutional distinction between those able to afford private abortions and those too poor to pay the cost of such services.[20] The Supreme Court's acceptance of this argument, especially as it is presently constituted, would set a dangerous precedent for areas other than abortion.[21] Nevertheless, pro-abortion forces will make every use they can of some of the extrinsic logic contained in the premise. Emotional factors alone can sway a court which is otherwise undecided. The trial court judge in the *Klein* case used some of this "discrimination against the poor" theory in his decision.[22]

The advent of national health insurance will have a tremendous impact on this argument. Once the affirmative obligation of the state to provide health care has been firmly established, any limitation imposed by the state on any type or category of health care will become constitutionally suspect. Even in a system which pays lipservice to the voluntary and private nature of health care delivery, the due process and equal protection arguments gain added weight as government intervention and involvement increase.[23]

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should be terminated. If that decision is reached, the judgment may be effectuated by an abortion *free of interference by the State.*

Roe v. Wade, 410 U.S. 113, 163 (1973) (emphasis added).

[20] Other cases discussing the question of "ability to pay" for constitutionally guaranteed protections and requiring the state to provide such services to the indigent in the criminal law area include: Anders v. California, 386 U.S. 738 (1967) (counsel on appeal); Draper v. Washington, 372 U.S. 487 (1963) (transcripts); Lane v. Brown, 372 U.S. 477 (1963) (transcripts for counsel on appeal); Douglas v. California, 372 U.S. 353 (1963) (counsel on appeal); Burns v. Ohio, 360 U.S. 252 (1959) (court filing fees); Griffin v. Illinois, 351 U.S. 12 (1956) (transcripts and filing fees).

[21] The Supreme Court has been very reluctant to abolish other financial barriers to the poor. In Boddie v. Connecticut, 401 U.S. 371 (1971), the Court held that divorce court fees must be waived for properly certified indigents. Subsequent cases have severly limited any further extensions into other areas. *See, e.g.*, United States v. Kras, 409 U.S. 434 (1973) (denied in forma pauperis access to the bankruptcy courts); Ortwein v. Schwab, 410 U.S. 656 (1973) (denied waiver of appellate court costs for civil appeal).

In both *Kras* and *Schwab* the Court spoke of the denial, due to poverty, of fundamental rights guaranteed under the Constitution. Such lines are artificial and once crossed, become almost limitless. If the state becomes obligated to provide all basic services to the poor, the definition of "basic" will be subject to great variations based upon our society's goals and norms. Such fluctuations are not generally considered a proper subject for the courts, but are better dealt with by the legislature.

[22] An essential ingredient of the court's determination that the state's refusal to fund voluntary abortions amounted to a denial of equal protection was the finding that such a refusal discriminated between poor and nonpoor women. Klein v. Nassau County Medical Center, 347 F. Supp. 496, 500-01 (E.D.N.Y. 1972), *vacated*, 412 U.S. 925 (1973).

[23] One trial court judge recently summed up the general popular attitude toward institutional health care delivery in the following terms: "It is my conclusion that private hospitals are

STATUTORY CLAIMS TO ABORTION

Presently, pro-abortion forces have an array of federal and state legislation in the health care field which they use to support their claims to government-financed abortions. The aforementioned Medicaid program is replete with provisions and enforcement regulations which, it can be argued, demonstrate the obligation of the government to provide free abortion and sterilization services.[24] Despite the fact that the states are given a tremendous amount of individual leeway in establishing and implementing their Medicaid programs,[25] certain "basics" are required in order to assure federal participation. One area in particular, family planning services, has been singled out for emphasis.

Family planning services were originally considered an optional benefit to be provided under Medicaid at an individual state's discretion. With the enactment of the comprehensive 1972 Medicaid and Social Security amendments,[26] these services became a mandatory part of Medicaid.[27] To the pro-abortionist, there is no question that family planning services include abortion. The fact that a congressional proscription against abortion was included in the amendments to Title VIII of the Public Health Services Act[28] hardly deters them.[29] They simply point out the recent failure of an anti-abortion amendment to the pending Health, Education, and Welfare (HEW) appropriations bill.[30]

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likewise not 'governmental in nature.' Unlike fire departments and police departments . . . hospitals are not traditionally governmental. Private hospitals are the rule rather than the exception." Barrett v. United Hospital, 376 F. Supp. 791, 799 (S.D.N.Y. 1974). How long that traditional attitude will remain in effect is, of course, the subject of much current debate.

[24] *See* 42 U.S.C. §§ 1396a(a)(13), 1396a(a)(1)—(5) (1970), wherein each state desiring to participate in the program is required to provide a minimum level of basic services, including physician and surgical services.

[25] *See* 42 U.S.C. §§ 1396a(a)(10), (14), (17), 1396d(a),(b),(c) (1970), wherein each participating state is permitted to limit certain aspects of the program as benefits its own needs. Among the areas subject to limitation are the types of services covered, the duration of hospitalization, and the percentage of state payment for each service rendered.

[26] Act of Oct. 30, 1972, Pub. L. No. 92-603, 86 Stat. 1329 (codified in scattered sections of 42 U.S.C.).

[27] 42 U.S.C. § 1396d(a)(4)(C) (Supp. II, 1972).

[28] 42 U.S.C. § 300a(6) (1970).

[29] In addition, many abortion proponents argue that the failure of Congress to include a similar specific prohibition on abortion spending in the Medicaid law implies that Congress intended abortion to be a Medicaid benefit. *See* Butler, *The Right to Abortion Under Medicaid*, 7 CLEARINGHOUSE REV. 713 (1974).

[30] On September 17, 1974, the U.S. Senate adopted a floor amendment sponsored by Senator Bartlett of Oklahoma prohibiting the use of any HEW funds "directly or indirectly to pay for or encourage the performance of abortions except such abortions as are necessary to save the life of the mother." Proposed Amend. No. 1859 to H.R. 15,580, 93d Cong., 2d Sess. (1974), *appearing in* 120 CONG. REC. S16,832 (daily ed. Sept. 17, 1974). The conference committee appointed by the full House and Senate rejected this addition in the final bill reported for passage by both houses.

This failure to sustain a limitation on abortion evidences one of the principal hazards facing the Right-to-Life adherents. Now, instead of having a piece of legislation completely neutral on the subject, there is a bill which has a strong legislative history of rejecting the anti-abortion position. Failure to enact a legislative program is regularly construed by courts as evidence of legislative intent. This may occur even if such a result was not originally intended.

An effort is now being mounted by the anti-abortion forces to exclude elective abortions from the list of services covered under any future national health insurance program. If not in the legislation itself, then in the subsequent battles which will provide the final determination, pro-abortion forces have an unwilling but very cooperative ally in fending off such an exclusion: *Church-related social action agencies in their enthusiasm for a strong and comprehensive universal national health program are playing right into the hands of those wishing to extend abortion.* Given the current trends in constitutional law, the wider scope of benefits and the more "federal" the program becomes, the more difficult it will be to limit the coverage. Not only will the battle for life be lost in this forum, but the continued independence of Church-related hospitals and other health care facilities will be seriously endangered.

CONCLUSION

Despite the efforts of anti-abortion forces to adopt a national constitutional amendment, the major arena in which the future of the abortion issue will be decided is still the courts. Whether or not the *Wade* and *Bolton* decisions will be expanded or limited is subject to judicial mandate. Early indications are that the pro-abortionists have gained an advantage in expanding federally financed abortion services. Anti-abortion forces are handicapped by the loss of many potential allies who, in their zeal for admirable social goals, have created constitutional and legal roadblocks to limiting abortion. The loss of any private impact on health care delivery is concurrent with the expansion of abortion and the federal guarantee of health care including, as a necessary consequence, abortion services.