IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1979

No. 79-1268

PATRICIA R. HARRIS, Secretary of Health, Education, and Welfare, *Appellant,*

v.

CORA McRAE, et al., *Appellees.*

PATRICIA R. HARRIS, Secretary of Health, Education, and Welfare, *Appellant,*

v.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, *Appellee.*

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NEW YORK

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IN THE

Supreme Court of the United States

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No. 79-1268

PATRICIA R. HARRIS, SECRETARY OF HEALTH, EDUCATION, AND WELFARE,

Appellant,

—v.—

CORA MCRAE, ET AL.,

Appellees.

PATRICIA R. HARRIS, SECRETARY OF HEALTH, EDUCATION, AND WELFARE,

Appellant,

—v.—

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION,

Appellee.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NEW YORK

BRIEF OF APPELLEES

OPINIONS BELOW

The opinion of the United States District Court for the Eastern District of New York of January 15, 1980 is not yet reported. See Motion of Defendant-Appellant to Dispense with Printing of the District Court's Opinion and the Accompanying Annex.

JURISDICTION

This is a civil proceeding to which the United States is a party and in which a series of Acts of Congress have been held unconstitutional: Pub. L. No. 94-439, § 209, 90 Stat. 1434 (1976); Pub. L. No. 95-205, § 101, 91 Stat. 1460 (1977); Pub. L. No. 95-480, § 210, 92 Stat. 1586 (1978); Pub. L. No. 96-123, § 109, 93 Stat. 126 (1979). The final judgment of the District Court was entered on January 15, 1980. The jurisdiction of this Court rests on 28 U.S.C. § 1252. Notice of Appeal to this Court was filed in the United States District Court for the Eastern District of New York on January 15, 1980 by the Defendant-Appellant, the Secretary of the Department of Health, Education and Welfare, and by the intervening Defendants-Appellants James L. Buckley, Jesse Helms, Henry T. Hyde, and Isabelle M. Pernicone on January 26, 1980. On February 5, 1980, Plaintiffs-Appellees moved this Court to hear arguments in tandem with *Williams v. Zbaraz*, 79-4, 79-5, 79-491. On February 11, 1980, Defendants-Appellants moved this Court for a stay of the District Court judgment pending appeal. On February 19, 1980, this Court denied Appellants' Motion, granted jurisdiction (79-1268), and ordered that this case be heard in tandem with *Williams v. Zbaraz,* 79-4, *Miller v. Zbaraz,* 79-5, and *United States v. Zbaraz,* 79-491. (A.332)

QUESTIONS PRESENTED

1. Does the Hyde Amendment violate the Due Process Clause of the Fifth Amendment?

a. Does the Hyde Amendment violate equal protection guarantees by excluding virtually all medically necessary abortions from a program that reimburses for all other medically necessary services?

b. Does the Hyde Amendment interfere with and penalize the liberty to protect one's health in the abortion context?

c. Is the Hyde Amendment void for vagueness?

2. Does the Hyde Amendment violate the Free Exercise Clause of the First Amendment as well as the Due Process Clause of the Fifth Amendment by infringing on the right of poor women to make conscientious decisions with their physicians, that abortions are necessary to their health?

3. Does the Hyde Amendment violate the Establishment Clause of the First Amendment?

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

1. The Establishment and Free Exercise Clauses of the First Amendment to the Constitution of the United States:

> Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof.

The Due Process Clause of the Fifth Amendment to the Constitution of the United States:

> No person . . . shall be deprived of life, liberty or property without due process of law.

2. The Social Security Act, 42 U.S.C. § 1396 (1976); 1396a(a) (1976); 1396b(a) (1976), *as amended by* Pub. L. No. 95-142, §§ 10(a), 17(a), 91 Stat. 1175 (1977); 1396b(p) (1976) *as amended by* Pub. L. No. 95-142, § 11(a), 91 Stat. 1175 (1977); 1396(d)a (1976), *as amended by* Pub. L. No. 95-210, § 2(a), 91 Stat. 1485 (1977); 1396f.

3. The Hyde Amendments: Pub. L. No. 94-439, § 209, 90 Stat. 1434 (1976); Pub. L. No. 95-205, § 101, 91 Stat. 1460 (1977); Pub. L. No. 95-480, § 210, 92 Stat. 1586 (1978); Pub. L. No. 96-123, § 109, 93 Stat. 126 (1979).

STATEMENT OF THE CASE

A. History of the Legislation

Harris v. McRae is a challenge to riders to the Labor-HEW Appropriations Act, generally known as "Hyde Amendments," which have been enacted annually since 1976. For four years the question of federal funding of abortions for poor women under Medicaid and other programs has been the subject of much Congressional debate. Each year the question of federal abortion funding has held hostage the annual HEW-Labor budgets.

The rider passed in 1976 to the Fiscal Year 1977 Act[1] was enacted over the President's veto on the last day of fiscal year 1976. The Conference Report, reached after four grueling sessions and finally adopted by both houses, provided that:

> None of the funds contained in this Act shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term. It is the intent of the conferees to limit the financing of abortion under the Medicaid program to instances where the performance of an abortion is deemed by a physician to be of medical necessity and to prohibit payment for abortions performed as a method of family planning or for emotional or social convenience. It is not our intent to preclude payments for abortions when the

[1] The riders will be referred to herein as FY 77-FY 80, reflecting not the year of their enactment but the budgetary year to which they apply, *e.g.*, the 1976 enactment will be referred to as the 1977 Hyde Amendment.

> life of the woman is clearly endangered, as in the case of multiple sclerosis and renal disease, if the pregnancy were carried to term; nor is it the intent of conferees to prohibit medical procedures necessary for the termination of an ectopic pregnancy or the treatment of rape or incest victims; nor is it intended to prohibit the use of drugs or devices to prevent implantation of the fertilized ovum. Pub. L. No. 94-439, § 209, 90 Stat. 1434 (1976).

The 1978 Hyde Amendment passed December 7, 1977 after almost six months of debate.[2] The compromise finally enacted contained three exceptions:

> None of the funds provided for in this paragraph 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, where such *rape* or *incest* has been reported promptly to a law enforcement agency or public health service; or except in those 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. Nor are payments prohibited for drugs or devices to prevent implantation of the fertilized ovum, or for medical procedures necessary for the

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[2] Following the initial House and Senate floor votes, the 1978 rider was the subject of seven conference committee sessions, nine House floor debates, ten Senate floor debates, and 27 floor votes. *See McRae v. Harris*, No. 76-C-1804 (E.D.N.Y., Jan. 15, 1980) Slip op. at 26 (hereinafter "Slip op."). A copy of legislative history is being lodged for the convenience of the Court.

> termination of an ectopic pregnancy. The Secretary shall promptly issue regulations and establish procedures to insure that the provisions of this section are rigorously enforced. (Emphasis added.) Pub. L. 95-205, § 101, 91 Stat. 1460 (1977).

The 1979 Rider, Act of Oct. 18, 1978, Pub. L. No. 95-480, § 210, 92 Stat. 1586, was identical.

The current Hyde Amendment, passed November 20, 1979 eliminated the severe and long-lasting health damage exception. Pub. L. No. 96-123, § 109, 93 Stat. 926.

The trial court found that the purpose of the Amendments was, simply, to prevent abortions. Slip op. at 165. The Amendments' proponents sought to nullify *Roe v. Wade*, 410 U.S. 113 (1973), and *Doe v. Bolton*, 410 U.S. 179 (1973), to the extent legislatively possible because they viewed abortion as the "taking of human life, and, therefore, not debatable." [3] Slip op. at 164. Appropriations riders were used because "efforts to bring the abortion issue to debate on a proposed constitutional amendment had failed." [4] Slip Op. at 21.

Moreover, the court found that the restrictions of the Amendments reflect a compromise "negotiated across an unbridgeable gulf of principle" (slip op. at 165), exacted only because of the tremendous pressure

[3] The trial court made extensive findings of fact on the legislative history and purpose of the Hyde Amendment. Slip op. at 16-43.

[4] Hearings on proposed "Human Life Amendments" were held by the Judiciary Committee of both Houses in 1975. Both Committees refused to approve an amendment for consideration by their respective bodies.

created by the need for the annual budgets. Slip op. at 278. "[T]he amendments are enactments of the House of Representatives to which the Senate has acceded, with such amendments as it could negotiate, rather than risk the appropriations bills." Slip op. at 279.

As such, the meager exemptions extracted each year disregard both the medical realities of pregnancy and professional standards of medical care.

In addition to the health issues, pro-choice legislators repeatedly asserted the constitutional and conscientious nature of the abortion right and the intolerability of imposing upon poor women the religious, moral view that condemns abortion. Their "every argument was met with the assertion that the fetus was inviolable human life, that there was nothing to discuss." Slip op. at 274.

B. History of the Litigation

Harris v. McRae is a class action filed October 1, 1976 seeking declaratory and injunctive relief against the Secretary of the Department of Health, Education and Welfare (hereinafter "HEW") to prevent implementation of the 1977 Hyde Amendment. Plaintiffs have amended the complaint to challenge the 1978, 1979, and 1980 "Hyde Amendments." [5] (A.58-80; A.90; A.95.)

[5] The following designations are used to refer to the documents filed with this Court in this litigation: "A."—Appendix; "R."—Record item (numbered according to the list of items transmitted to this Court by the district court on March 21, 1980; "Pl. Exh./T." refers to the transcript page at which the document was admitted in evidence. No transcript reference is available for Plaintiffs' Exhibits 8a, 200-290, which were put into evidence on August 2 and 3, 1978, or for Plaintiffs' Exhibits 300-471, which were admitted by Court Order on February 14, 1980. (A.96-97.) Plaintiffs have lodged for the convenience of the Court state laws and poli-

Plaintiffs-appellees include:

(1) CORA McRAE, from New York, and four anonymous Medicaid-eligible women from Connecticut and Minnesota who were denied Medicaid reimbursement for abortions even though their doctors concluded that their abortions were medically necessary because of physical and mental health indications. They represent a certified nationwide class of indigent pregnant women seeking abortions which their doctors consider medically necessary.[6]

(2) DRS. IRWIN B. TERAN, JANE HODGSON, DAVID B. BINGHAM, HUGH SAVAGE, EDGAR W. JACKSON, and LEWIS H. KOPLIK, physicians from New York, Connecticut, Texas, New Mexico and Georgia, who would be willing to perform medically necessary abortions for indigent pregnant women but for the absence or threatened absence of Medicaid reimbursement because of the Hyde Amendment. They represent a nationwide class of such providers.

(3) The WOMEN'S DIVISION OF THE BOARD OF GLOBAL MINISTRIES OF THE UNITED METHODIST CHURCH and two officers, on behalf of themselves and their membership, among whom are

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cies enacted pursuant to the Hyde Amendments (Vol. I), critical medical articles placed in evidence (Vol. II), legislative history (Vol. III), and key religious documents (Vol. IV).

[6] The October 22, 1976 decision certified plaintiffs' classes of indigent eligible women and abortion providers and permitted intervention as defendants by Isabelle E. Pernicone as *guardian ad litem* and by Senators Buckley and Helms and Congressman Hyde as taxpayers. *See McRae v. Mathews*, 421 F. Supp. 533 (E.D.N.Y. 1976). The classes were recertified on January 29, 1979, and in the final judgment of the Court. (A.92-94; A.86-87.)

indigent pregnant women who are dependent on Medicaid to obtain safe abortions which are medically necessary and who object to the imposition on them of religious beliefs about abortion which they do not share, thereby preventing exercise of their freedom of conscience.

(4) PLANNED PARENTHOOD OF NEW YORK CITY (PPNYC), a not-for-profit New York corporation providing family planning services and first trimester abortions at state licensed clinics. The Hyde Amendments have placed their receipt of state and local funds for medically necessary abortions in jeopardy.

(5) The NEW YORK CITY HEALTH AND HOSPITALS CORPORATION (NYCHHC), is a public benefit corporation charged with the responsibility for providing comprehensive health and medical services to the residents of New York City. The NYCHHG operates 18 municipal hospitals, 12 of which perform abortions. As the largest single provider of medically necessary abortions to indigent pregnant women in New York City, the NYCHHC appears to defend its fiscal interest in reimbursement for these abortions to preserve its overall economic capacity to render adequate medical care to all its patients.[7]

The district court issued a preliminary injunction preventing implementation of the original Hyde Amendment. *McRae v. Mathews*, 421 F. Supp. 533 (E.D.N.Y. 1976). On June 29, 1977, this Court vacated that judgment and remanded the case to the district

[7] *New York City Health and Hospitals Corporation v. Mathews*, No. 76-C-1805, was simultaneously filed and proceeded as a companion case to *McRae*. The two cases have been informally consolidated for this Court's review.

court for reconsideration in light of *Beal v. Doe*, 432 U.S. 438 (1977), and *Maher v. Roe*, 432 U.S. 464 (1977). (R.56.)

On August 4, 1977, the district court vacated its order and HEW immediately implemented the 1977 Hyde Amendment. Evidentiary hearings began on August 3, 1977, and continued intermittently for over a year.

On January 15, 1980, the district court held the Hyde Amendment unconstitutional under the Fifth and First Amendments and ordered HEW to fund all medically necessary abortions. (R.219, A.86.) A stay of the injunction was ordered for 30 days.[8] (R.220.) On February 19, 1980, this Court noted probable jurisdiction, denied defendant's and defendants-intervenors' motion for a stay, and granted plaintiffs' motion to hear argument in tandem with *Williams v. Zbaraz*, No. 79-4; *Miller v. Zbaraz,* No. 79-5; *United States v. Zbaraz,* No. 79-491. *Harris v. McRae,* No. 79-1268. (A.332) Accordingly, on that date, defendant HEW sent a notice to all Regional Commissioners to inform states, medical providers, and recipients of the distict court's order and of the states' obligation to fund medically necessary abortions in their Medicaid programs.

[8] Judgments and orders of the district court of January 15, 1980 were appended to the Government's Application for a Stay of the Judgment of the District Court Pending Appeal.

C. Facts

1. Introduction

On remand, the district court made extensive findings of fact, based largely on undisputed evidence. Plaintiffs presented over 30 witnesses, including acknowledged medical experts and theologians. A description of these witnesses is included in the appendix at the end of plaintiffs' brief. Nearly 500 exhibits, including official HEW documents and unpublished studies and data, were introduced into evidence.

Plaintiffs introduced evidence on the meaninglessness of the "life-endangering and severe and long-lasting physical health damage" standards of the Hyde Amendments in the context of the medical realities of pregnancy. Plaintiffs' proof further addressed the religious nature of the abortion decision, the irreconcilable religious differences over abortion, and the religiosity of the Hyde Amendments. Defendant HEW offered no medical or religious witnesses. Defendants-intervenors presented both medical and religious testimony, which the trial court found not inconsistent with plaintiffs' evidence. Slip op. at 99-100.

The findings of fact include the probable impact of the Hyde restrictions, as well as their actual impact where they have been implemented. The findings conclude that the Hyde Amendments were designed to prevent abortions, not to encourage normal childbirth or to fulfill any medical need, and that most women who need abortions to avert unacceptable health risks are not covered by the Amendments. Slip op. at 318, 322-23. Moreover, the trial court found the standards so vague and unworkable that even those women whose lives are in fact endangered are not receiving needed Medicaid abortions. Slip op. at 91, 110, 322-23.

2. Implementation of the Hyde Amendment Resulted in States Adopting the Hyde Standard or a Similar Standard for Medicaid Abortions.

When the Hyde Amendment first went into effect on August 4, 1977, virtually every state was funding all, or all medically necessary, abortions.[9]

The Court below found that "... the Hyde Amendment has precipitated changes in state law and Title XIX plans that depend for their validity on the validity of the challenged Amendments." Slip op. at 283.

Most states reacted in 1977 by restricting their own funding to the Hyde standard.[10]

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[9] As of July 24, 1977, an informal state survey revealed that three states had already adopted restrictive policies similar to the Hyde Amendment, but were under court injunctions: Missouri, New Jersey, North Dakota. *Wulff v. Singleton*, 508 F.2d 1211 (8th Cir. 1976), *aff'd in part and remanded*, 428 U.S. 106 (1977) (this action was dismissed by plaintiffs, without prejudice, on July 1, 1977 as per *Beal v. Doe*, *supra*, and *Maher v. Roe*, *supra*); *Doe v. Klein*, No. 76-74 (D.N.J. Feb. 2, 1976) [preliminary injunction]; (D.N.J. June 27, 1977) [preliminary injunction dissolved in light of *Doe v. Beal, supra*] *aff'd* No. 77-2026 (3rd Cir., Jan 10, 1978); *Doe v. Myatt*, No. A3-74-48 (D.N.D., Jan. 27, 1975), (Oct. 30, 1976). Arizona is unaffected because it is the only state with no Medicaid program. *See* Janet Benshoof Aff., July 24, 1977. (R.48)

[10] *Alabama*: Special Alabama Medicaid Information Letter, FP-77-2 (August 25, 1977);

Arkansas: State of Arkansas, Dept. of Soc. and Rehabilitative Services, MSP-77-A/B-24 (August 8, 1977);

Connecticut: State of Connecticut, Dept. of Soc. Services, Health Services Bull. No. 58 (Aug. 19, 1977);

Delaware: Dept. of Health and Soc. Services, Release (August 5, 1977);

Florida: Florida Ad. Code, Emergency Rule 10-CER-77-36 (Amendment to State of Florida, Ad. Rules, Chapter 10C-738) (Sept. 1, 1977);

Georgia: GA. CODE ANN. § 96-4616 (1977) [state will not cover services for which it does not receive federal matching funds];

Some states could not choose to continue coverage since state law requires them to pay only for those

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Indiana: Medicaid Division, State Dept. of Public Welfare, Memo (Aug. 9, 1977);

Kansas: State Dept. of Soc. and Rehabilitative Services, Secretary's L-192 (Dec. 1, 1977);

Kentucky: Bureau for Soc. Insurance, Dept. for Human Services, Hosp. Letter No. A-55, Phys. Letter No. A-56, Family Planning Letter No. A-3;

Louisiana: Office of Family Services, Dept. of Health and Human Resources, Physician Letter (Oct. 12, 1977);

Maine: Maine Dept. of Human Services, Revision of Medicaid Policy on Abortions, (Aug. 9, 1977);

Minnesota: Minn. Dep't of Public Welfare, Press Release (Sept. 23, 1977);

Mississippi: Mississippi Medicaid Commission, Memo, Restrictions on Medicaid Payment for Abortions (Aug. 8, 1977);

Montana: State of Montana, Economic Assistance Division, Soc. and Rehabilitation Services, Memo (Aug. 5, 1977);

Nebraska: Dept. of Public Welfare, Policy Statement (Sept. 1, 1977);

Nevada: State Welfare Assistance, State Assistance for the Medically Indigent (S.A.M.I.), Bull. No. 88;

New Mexico: Medical Assistance Manual § 319.2-0 (Oct. 1, 1977);

North Carolina: Division of Soc. Services, Dept. of Human Resources, Policy Statement (August 8, 1977);

North Dakota: Soc. Services Board, Memorandum, Oct. 20, 1977;

Ohio: Division of Medical Assistance, Dept. of Public Welfare, Medical Assistance Letter No. 64 (Sept. 8, 1977);

Oklahoma: State of Oklahoma Public Welfare Commission, Dept. of Institutions, Social and Rehabilitative Services Letter (June 2, 1978);

South Carolina: South Carolina Dept. of Soc. Services, Circular Letter No. 2320 (Aug. 18, 1977);

Tennessee: Dept. of Public Health, Official Notice (Aug. 9, 1977);

Texas: Texas Medical Assistance Program, Medicaid Bull. (Sept. 1977);

Utah: Office of Medical Services, Dept. of Soc. Services, Notice (Aug. 23, 1977);

Vermont: Agency of Human Services, Soc. Welfare Bull. No. 77-66 (Aug. 10, 1977);

services for which there is federal reimbursement.[11] Some adopted a facially more restrictive standard.[12] A few states continued to provide reimbursement at state expense for medically necessary abortions.[13] When the Hyde standard changed in 1978, many states changed along with it.[14]

Wyoming: State of Wyoming Division of Public Assistance & Soc. Services, Dept. of Health & Social Services, Memo No. M-205-77 (Sept. 26, 1977).

State policies were put into evidence at Pl. Exh. 258a-uu. State policies, regulations, and statutes following implementation of the Hyde Amendment have been lodged in a separate volume for the convenience of the court as Vol. I.

[11] *See* Georgia: GA. CODE ANN. § 99-4616; Texas Constitution, Article 3 § 51A; Delaware, House Bill No. 333, Appropriations FY ending June 1980, Sec. 19(a)(ii).

[12] Missouri, for example, limited abortion funding to situations where continuation of the pregnancy "would cause cessation of the mother's life." Mo. 13 C.S.R. 40-81.100 (1977). Rhode Island and Illinois also used a "preserve life" standard. Rhode Island, State of Rhode Island, Dept. of Soc. and Rehabilitative Services, Policy & Procedure to be Followed in Order to Determine Medical Necessity for Abortions (Oct. 1, 1977), P.A. 80-191; Ill. Rev. Stat. §§ 5-5, 6-1, 7-1 (Supp. 1977). In New Jersey a court injunction was lifted and a "preserve life" standard implemented. N.J.S.A. 30:406.1 *See Doe v. Klein, supra.*

[13] Alaska, California, Colorado, Hawaii, Idaho, Maryland, Massachusetts, Michigan, New Hampshire, New York, Oregon, Pennsylvania, South Dakota, Virginia, Washington, Wisconsin, and the District of Columbia.

[14] *Alabama*: State of Alabama, Medical Services Administration letter (Feb. 22, 1978);

Arkansas: State of Arkansas, Division of Soc. Services, Dep't of Human Services, Memorandum MSP-77-A/B-24 (Dec. 22, 1977);

Delaware: House Bill No. 888, Sec. 37(b)(iii). Appropriations for FY ending June, 1979 [state funds appropriated for medical assistance under Title XIX shall only be expended where federal matching funds are provided];

Georgia: GA. CODE ANN. § 99-4616 (1977) [state will not cover services for which it does not receive federal matching funds];

Indiana: State of Indiana, Dep't of Public Welfare, Ad. Bull. (Dec. 15, 1977);

Maine: Maine Medical Assistance Manual, Chapter III, Sec. 15, (Aug. 21, 1978);

Mississippi: Blue Cross/Blue Shield of Mississippi, Fiscal Agent Medicaid Program, Medicaid Bull. No. Phys./Hosp. 78-2 (April 18, 1978);

Montana: State of Montana, Economic Assistance Division, Soc. and Rehabilitation Services (Jan. 5, 1978);

Nevada: Nevada State Welfare Division, State Assistance for the Medically Indigent (S.A.M.I.), Bull. No. 97 (July 19, 1978);

New Mexico: State of New Mexico, Dep't of Human Services, Human Services Register, Vol. 1, No. 7 (June 26, 1978);

Ohio: Ohio Dep't of Public Welfare Medical Assistance Letter [M.A.L.] No. 71 (Jan. 5, 1978);

Oklahoma: State of Oklahoma Welfare Commission, Dep't of Institutions and Rehabilitative Services (Dep't of Public Welfare, Form letter);

South Carolina: South Carolina Dep't of Soc. Services, Circular Letter No. 2320-A (Feb. 24, 1978);

Tennessee: State of Tennessee Bureau of Medicaid, Dep't of Public Health, Official Notice (June 6, 1978);

Texas: Texas Agency Rules § 326.3612.021 (Aug. 18, 1978);

Vermont: Vermont Welfare Assistance Manual § 2461.7 (Nov. 1, 1978);

Wisconsin: State of Wisconsin, Division of Health, Dep't of Health and Soc. Services, Medical Assistance Provider Bull. MAPB-78-004-A, 005-B (April 5, 1978).

Iowa reimbursed for terminating pregnancies which were life-endangering, the result of rape, incest, or where the fetus was "physically deformed, mentally deficient or afflicted with a congenital illness." State of Iowa, Dep't of Soc. Services, Soc. Services Circular Letter 143 Med (No. 75) (May 30, 1978). California and Maryland also provided for abortions in cases of fetal defect. The California policy also covered: first trimester abortions for victims of rape; first and second trimester abortions for victims of incest, where the incident had been reported; first trimester abortions where two physicians had certified that there was a threat of severe and long-lasting health damage due to a specifically cited condition; and abortions for females under sixteen if their parents had been informed. California State Statutes of 1978, Chap. 359. The Maryland policy also allowed for abortions when the mother's life or health was threatened, and in cases in which the pregnant woman was the victim of sexual assault which had been reported. COMAR 10.01.02.04K.

Others retained the 1977 standard.[15] Still others adopted or retained more restrictive standards,[16] and a few continued reimbursement with state funds.[17]

Although the Hyde standard was unchanged in 1979, some states moved to more restrictive policies.[18]

[15] Connecticut, Florida, Kansas, Nebraska, North Dakota, Utah, Wyoming. *See* n. 14, *supra*. Virginia went from funding all abortions to the 1977 Hyde standard. Virginia Dep't of Health, Memo: Abortions Covered by Medicaid (Dec. 12, 1977). Massachusetts, which had funded all abortions, restricted reimbursement to life-endangerment, rape, and incest. Mass. Stat. 1978, c. 367, § 2, Item 4402-5000.

[16] Rhode Island and New Jersey retained their 1977 "preservation of life standards; Missouri kept its "cessation of life" standard; and Kentucky and Louisiana enacted similarly strict laws. KY REV. STAT. § 205.510(3) (June 17, 1978); LA. REV. STAT. 40:1299.35. Pennsylvania and South Dakota, which had been funding all or medically necessary abortions, enacted statutes using "save the life" and "preservation of life" standards. Pa. Act No. 1978-148; S.D. COMP. LAWS ANN. § 28-6-4.5. Minnesota permitted reimbursement to "preserve life" and in cases of rape and incest.

Minnesota's policy allowed for reimbursement for abortions after rape, if the assault was reported within forty-eight hours after the victim became physically able to make the report, and after incest if the incident was reported prior to the time of the abortion. MINN. STAT. ANN. § 256B.02, Subd. 8 (1978).

[17] Alaska, Colorado, Hawaii, Idaho, Maryland, Michigan, New York, Oregon, Washington, D.C.

[18] Indiana adopted a "preserve life" standard less than a year after it adopted the 1978 Hyde standard. 1979 Ind. Acts No. 1414 P.L. 153, Sec. 1 [amending IC 16-10-3]. Idaho shifted from reimbursing for abortions "necessary to save the life or health" of the woman to the 1978 Hyde standard. Bureau of Medical Assistance, Idaho Dep't of H.E.W. § 3-1413. North Dakota changed from a life-endangering standard to a standard forbidding all public funds for performing or "promoting the performance, of an abortion unless the abortion is necessary to prevent the death of the woman." N.D. Cent. Code § 14-02.3-01 (1979). However, Florida in 1979 adopted the 1978 Hyde Amendment standards.

In 1980, several states followed the congressional lead and eliminated the "severe and long-lasting physical health damage" provision.[19] Only one state has substantially liberalized its abortion funding policy after restricting it pursuant to the first Hyde Amendment.[20]

States had no guidance from HEW which, until recently, refused to take a position on the effect of the Hyde Amendments on the states' underlying obligations under the Social Security Act.[21] Repeated inquiries from state officials and courts went unanswered.[22] In his comments on the regulations, Secretary Califano carefully noted that:

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[19] *Alabama*: State of Alabama, Medical Services Ad., Memo (Oct. 25, 1979);

Arkansas: State of Arkansas, Division of Human Services, Official Bulletin (Dec. 17, 1979);

Delaware: House Bill No. 333, Sec. 19(a)(iii), Appropriations, FY ending June, 1980;

Georgia: GA. CODE ANN. § 99-4616 (1977);

Mississippi: Blue Cross/Blue Shield, Fiscal Agent Medicaid Program, Medicaid Bull. Nos. Hosp./Phys. 80-1 & 2 (Jan. 30, 1980);

Nevada: Nevada State Welfare Division, Medicaid Manual § 703.4 (Oct. 24, 1979);

New Hampshire: Division of Welfare, Medical Assistance § 9624.3 (Item 926) (Feb. 1979, SR-79-18);

Oklahoma: Oklahoma Public Welfare Commission, Dep't of Institutions, Soc. and Rehabilitative Services (Dep't of Public Welfare Form Letter);

Texas: Texas Agency Rules § 326.3612.021 (1980);

Vermont: State of Vermont, Agency of Human Services, Dep't of Soc. Welfare, Memo (Dec. 7, 1979).

[20] North Carolina Ad. Code, Human Resources—Individual and Family Support, Subchapter 42W.0001.

[21] It is the current position of HEW that Title XIX of the Social Security Act requires states to reimburse for all medically necessary abortions, as long as federal reimbursement is available. *See* U.S. Brief, *Williams* v. *Zbaraz*, No. 79-4, n. 23 at 43.

[22] In April, 1978, HEW advised a Maryland state legislator that it had not yet determined whether the states were obligated to

These regulations only govern the instances where federal funding is available for abortions and other medical procedures. They do not deal with the separate question of circumstances under which a state must fund abortions under the Medicaid program. 43 Fed. Reg. 31868, 31875 (1978).

No administrative actions were ever taken by HEW against those states which restricted coverage beyond the then current Hyde Amendment.

Litigation has, to a considerable extent, changed the pattern of state funding. Of the 23 states which were reimbursing for all, or all medically necessary, abortions before the nationwide injunction issued by the district court went into effect, 14 were doing so under a court injunction.[23] On March 10, 1980, the Tenth Circuit struck down the restrictive Utah statute and ordered funding of all medically necessary abortions. *D. R. v. Mitchell*, No. 78-1675 (10th Cir., March 10, 1980).

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fund all medically necessary abortions (Pl. Exh. 274 A & B). Responding to another inquiry from Nebraska, the Department stated that it had no position concerning a state's right to implement a policy more restrictive than the Hyde standards. (Pl. Exh. 275 A & B).

[23] Calif.: *Committee to Defend Reproductive Rights v. Cory*, S.F. No. 24053 (Cal. Sup. Ct., Sept. 20, 1979) (staying operation of restrictive statute); Conn.: *Women's Health Services, Inc. v. Maher*, Civ. No. H-79-405 (D. Conn., Jan. 7, 1980); Ga.: *Doe v. Busbee*, 471 F. Supp. 1326 (N.D. Ga., 1979); Ill.: *Zbaraz v. Quern*, 469 F. Supp. 1212 (N.D. Ill. 1979), *appeal granted juris. postponed*, *Williams v. Zbaraz*, *Miller v. Zbaraz*, *U.S. v. Zbaraz* (Nos. 79-4, 5, 491), 48 U.S.L.W. 3356 (Nov. 26, 1979); La.: *Emma G. v. Edwards*, No. 77-1342 (E.D. La., Nov. 27, 1978); Mass.: *Preterm Inc. v. Dukakis*, 591 F.2d 121 (1st Cir. 1979), *cert. denied* No. 78-430, 99 S. Ct., 2182 (1979)); Minn.: *Hodgson v. Board of County Commisioners*, 3 Medicare & Medicaid Guide (CCH)

3. The Impact of the Hyde Amendment Has Been to Limit Medicaid Abortions, in a Random Manner, to Only 1% of Those Poor Women Who Obtained Them Prior to Its Implementation.

The Hyde Amendment has had a devastating effect on a significant number of poor women for whom an abortion is medically necessary because their pregnancies threaten their lives and health. *See* Section C.5, *infra*. The trial court found that where restrictive standards have been implemented, the vast majority of medically necessary abortions have been excluded from Medicaid coverage and abortion has been relegated "... to a procedure limited to crisis intervention in cases with fully developed symptoms. . . ." [24] Slip op. at 158-59.

The data from states which have implemented a Medicaid standard more restrictive than "medically necessary" shows that since fiscal year 1976—the last year Medicaid monies were provided for all or most

¶ 30,159 (8th Cir. Jan. 9, 1980)(No. 79-1665); Mo.: *Reproductive Health Services v. Freeman*, 3 Medicare & Medicaid Guide (CCH) ¶ 30,160 (8th Cir., Jan. 9, 1980)(No. 79-1275); Neb.: *Orr v. Nebraska Dept. of Public Welfare*, Civ. No. 80-031 (D.Neb. Jan 25, 1980); N.J.: *Right to Choose v. Byrne*, 398 A. 2d 587 (N.J. Super. Ct. Ch. Div. 1979); Ohio: *Planned Parenthood Affiliates v. Rhodes*, 477 F. Supp. 529 (S.D. Ohio 1979); Pa.: *Roe v. Casey*, 464 F. Supp. 487 (E.D. Pa. 1978); W. Va.: *Smith v. Ginsburg*, No. 75-0380 CH (S.D.W. Va. May 9, 1978); Wis.: *Doe v. Percy*, 476 F. Supp. 324 (W.D. Wisc. 1978).

[24] Brief of the United States in *Williams v. Zbaraz*, n. 30 at 59, states that ". . . it is unwarranted to assume . . . that a pregnant woman must actually be near death before she can receive Medicaid funds for an abortion." The statistics presented in this case prove, and the district court so found, that such an assumption is absolutely correct. Slip op. at 58-61. *See* Pl. Exh. 24, p. 209; Pl. Exh. 177/T.4879, A.289, A.141-45.

abortions—the number of funded abortions has decreased 98-99%. (Pl. Exh. 177/T.4879, A.289.) For all states, the approximate number of federally funded abortions went down from 260,800 in 1976 to about 2,767 in 1978, a decrease of 99%.[25] (Pl. Exh. 24, p. 209/T.1534., A.262; A.143.) For the last quarter of 1978, 28 states, Puerto Rico, and the District of Columbia reported *no* abortions qualifying for federal reimbursement under the 1978 Hyde standard. (p. 5, A. 142.) The evidence shows that the precise wording of the restrictive standard is virtually irrelevant. The statistics confirm the medical testimony that under the Hyde standard, or any standard more restrictive than "medically necessary", [26] the number of Medicaid abortions will be drastically reduced. (Jaffe, T. 4873.) Even women who would qualify under the restrictive standards will not actually be covered because the standards are unclear to physicians. Slip op. at 322-23.

Statistics from 22 states which reported Medicaid abortions for the last quarter of 1978 show that seven states, reporting 130 of the 780 Medicaid abortions, reported none under rape or incest and none under severe and long-lasting physical health damage.[27]

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[25] HEW statistics report 2421 abortions from Feb. 14, 1978 to Dec. 31, 1978. The annual number would then be about 2,767. (A.143)

[26] A broad construction of the term life-endangerment to include health considerations by the State of Virginia (*see Doe v. Kenley*, 584 F.2d 1362 (4th Cir. 1978) has made no difference whatsoever. For 1978 Virginia reported only nine Medicaid abortions (A.144), a decrease of 99.8% from 1976 when Virginia covered 5,200 Medicaid abortions. (Pl. Exh. 24, p. 209/T.1534, A.262.)

[27] The fear was expressed in Congress that the elimination of "forced" before "rape" would lead to widespread use by teenagers who would qualify under statutory rape. Annex to slip. op. at 212,

(A.141.) Illinois, reporting 59 abortions over three months, assigned 15 to life endangerment, 41 to severe and long-lasting health damage, and three to rape and incest. Illinois accounted for 47% of the cases assigned to severe and long-lasting health damage in the last quarter of 1978. Slip op. at 60.

These statistics support the trial court's finding that the Hyde standard, indeed any standard other than "medically necessary," is so unworkable that it limits Medicaid abortions to crisis situations, and does not even provide funded abortions for the few women intended to be covered. Slip op. at 99-100, 159, 322-23.

4. Plaintiff Class Members, for Whom Abortion Is Medically Necessary, Have Suffered Increased Health Risks Because of the Hyde Amendment.

Plaintiff class members include Medicaid-eligible women for whom abortions are medically necessary, but who do not qualify under the Hyde Amendments. (A.59-61.)

In 1976, HEW estimated it financed between 250,000-300,000 abortions. Slip op. at 14. The number of poor women who wanted abortions but could not get them was undoubtedly higher.[28]

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281. 123 Cong. Rec. H 10834 (daily ed. Oct. 12, 1977), 123 Cong. Rec. H 12489 (daily ed. Nov. 29, 1977). The statistics show this fear was unfounded. In the fourth quarter of 1978, there were only 25 rape and incest abortions reported in the entire country, 14 were from Oregon. (A.141.)

[28] One HEW official estimated that in 1973, there were probably over 1 1/2 million unwanted pregnancies of Medicaid women annually; this represents almost half of all welfare recipients of childbearing age. (Pl. Exh. 214, p.9) Slip op. at 15.

The number of these pregnancies which present a health risk to the woman is unknown, but substantial.[29] (See Section C-5, *infra.*) The limited data at the time of trial showed that the impact of the Hyde Amendments has been to cause increased risks to life and health.

An article published by doctors working at the United States Center for Disease Control (CDC) estimated that if publicly-funded abortions were restricted in all states, from 5 to 90 excess deaths would result for poor women of childbearing age in the United States each year. (Pl. Exh. 240, p. 6, A.296.) The analysis was based on increased mortality risks which accompany each of the three alternatives available to poor women: delay in getting money to pay for a legal abortion; choosing a non-legal abortion; or choosing to carry a pregnancy to term. This article does not deal with the increased risk of serious complications due to illegal abortion (estimated to be about 100 times the number of deaths from illegal abortions)(Tietze, A.200), nor the effects on health of carrying a complicated pregnancy to term.

The full impact of the funding restrictions on the plaintiff class is unknown for several reasons. First, funding restrictions have affected only about 20% of the plaintiff class, since the most populated states have thus far continued funding.[30] Second, there is no com-

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[29] The plaintiffs-appellees' in *Williams v. Zbaraz* point out that under a medically necessary standard in 1978, Illinois funded about 10,666 abortions, less than 50% of the number it had funded in 1977, (21,663), when both elective and medically necessary abortions were reimbursed (Brief of Appellees, at 7).

[30] The number of women at risk has varied greatly because court orders and states on their own, have changed policies. (See Section

plete reporting system for complications arising from illegal abortions, as there is for Medicaid deaths.[31] Further, since reporting and investigation on abortion deaths can take up to 24 months (Pl. Exh. 260, p. 6), and the increased mortality of women forced to carry complicated pregnancies to term takes months to ascertain, that data has not yet been compiled.[32] The CDC noted that, in 1977, "for the first year since 1972, there was an increase in the annual number of illegal abortion deaths." Slip op. at 70. (Pl. Exh. 260, p. 15.)

C-3, *supra*.) Although, 23 states and the District of Columbia were funding, as of February 19, 1980, because so many of the injunctions are recent, the figure of 20% is more accurate when gauging impact.

[31] The trial court found, upon examination of all available data, that the extent of hospitalizations resulting from botched illegal abortions was "indeterminate." Slip op. at 74. Defendants provided information on a 24-year-old black woman who, in her 12th week of pregnancy, unsuccessfully sought an abortion in South Carolina. She could not obtain one because she could not afford the fee, and was aborted illegally in February 1978, apparently in her 16th week, when mortality risk is much higher. She was later hospitalized for post-abortion complications that necessitated a hysterectomy, rendering her sterile. Slip op. at n.27. (R.122, pp.4-6.)

[32] There is some evidence of increased childbirth, *see* Brief of Appellees in *Williams v. Zbaraz*, at 18-19, footnote. In *Women's Health Services Inc. v. Maher*, Civ. No. H-79-405, (slip op. at 13) (D. Conn. Jan. 7, 1980), the trial court made a finding of fact that, in one sample, 37% of those women seeking medically necessary abortions in Connecticut were "forced to carry their abnormal pregnancies to term." On the other hand, the trial court in this case found that "in Romania, where abortion was sharply restricted commencing in November 1966, the effect was a drastic increase in hospital admissions for complications arising from illegal abortion and a sharp increase in abortion-related maternal deaths; a short-term increase in birth rate was followed by a decline in birth rate, ascribed by Tietze and Murstein to resort to 'folk methods of contraception and illegal abortion.'" Slip op. at 67-68. (Pl. Exh. 13, p. 65/T.1040.)

CDC concludes that the implementation of the Hyde Amendment may have been responsible for several deaths, and was certainly responsible for the death in 1977 of a Mexican-American woman who had had two previous Medicaid abortions.[33] She resorted to obtaining a low-cost abortion from a lay midwife on September 16, 1977, about a month after Texas implemented the Hyde Amendment. Despite intensive care, she died in imminent septic shock. Slip op. at 71.[34]

The trial court found that the risk of serious complications increases 20% and the risk of death increases 50% for each week abortion is delayed (slip op. at 65), and that Medicaid-eligible women who eventually obtained abortions in non-funding states did so only after delay, thereby increasing risks:

> The evidence requires the conclusion that the consequence of the legislation has been at the very minimum to delay abortions with the serious consequence of increasing maternal mortality risks,

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[33] The draft summary of the 1977 report states:

> Public policy decisions may have created an environment of uncertainty for low-income women about the availability of legal abortion services, whether they lived in states which were continuing public funding for abortion or those which were not. However, because of the small numbers involved, chance fluctuation of a rare event is a possible explanation for this increase in illegal abortion-related deaths. Moreover, for at least one woman, the non-availability of public funds led to a situation in which was forced to choose the less safe, illegal abortion because of financial factors. (Pl. Exh. 260, p.14.) Slip op. at 72.

[34] Plaintiffs ask this Court to take judicial notice of the fact that, subsequent to the trial in this case, CDC found four illegal abortion deaths relating to the Hyde Amendment. *See* Associated Press article, Boston Globe, February 12, 1980, p. 3. A copy of this article is attached to plaintiffs' papers in opposition to defendants' motion for a stay, February 12, 1980.

that the restrictions on funding have in fact caused some resort to illegal abortion, although the extent of that is not measurable, and that in fact Medicaid-eligible women who wish to terminate their pregnancies have no significant alternative to Medicaid for obtaining abortion.[35] Slip op. at 158.

5. The Hyde Amendment Standard Does Not Cover the Vast Majority of Medical Problems which May Make Abortion Medically Necessary.

The trial court found, in exacting detail, that the Hyde Amendment standards, whether life-endangering or, as in 1978 and 1979, life endangering plus severe and long-lasting physical damage, "do not include but exclude the greater part of the cases in which the profession would recommend abortion as medically necessary procedure to safeguard the pregnant women's health." Slip op. at 308. The denial of medically necessary abortions does not and cannot further any interest in "normal" childbirth and exacts a toll on poor women in terms of the effect on their lives and health. Slip op. at 311, 158.

It is undisputed that pregnancy represents a greater than normal risk of morbidity and mortality for some women than for others. Slip op. at 88-9. Whether the

[35] Delay caused by trying to raise the money involves more than increased risks to the woman's life or health. One court recently found that, of 144 poor women seeking abortions, the 63% who were able to raise the money did so by "not paying rent or utility bills, pawning household goods, diverting food and clothing money or journeying to another state to obtain lower rates or fraudulently using a relative's insurance policy . . . some patients were driven to theft." *Women's Health Services, Inc. v. Maher*, Civ. No. H-79-405 (slip op. at 14) (D. Conn. Jan. 7, 1980).

risks are such that, considering all factors,[36] an abortion is medically necessary, is ". . . inescapably a medical question that must be resolved in terms of many variables of time, of patient's will, of patient's medical history, of patient's family situation, and of the patient's mental health and her age." Slip op. at 160.

a. Physical Factors Cause High Risk Pregnancies.

There are numerous pre-existing conditions and complications which occur because of pregnancy which may be important factors in determining an abortion to be medically necessary, but which cannot be certified under Hyde standards.[37] The result is that women's health is sacrificed, and doctors are forced to forego exercising their best medical judgment.

Plaintiff Jane Doe is a 25-year-old woman with four children. Following the birth of her third child, she developed a serious case of phlebitis, which had required lengthy hospitalization. (Doe Aff., § 3, A.109; Hodgson Aff., § 3, A.111,195.) Continuing her pregnancy would greatly aggravate that condition and increase the risk of blood clots to the lung. (Hodgson,

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[36] For a complete list of 84 factors compiled by eminent obstetricians to be considered in whether pregnancy or childbirth will have a higher than normal risk, plaintiffs submitted into evidence criteria used by the Maternity Center Association, an out-of-hospital birthing center in New York. (Romney, T./ 1138.) A cumulative score of two points made women unacceptable for the program and women were reevaluated throughout their pregnancies. (Pl. Exh. 18/T. 1138) The trial court found the list to "traverse the range of factors that can at varying intensity levels become indications for termination of pregnancy." Slip op. at 94-5.

[37] *See* Brief *Amici Curiae* of Planned Parenthood Federation of America, *et al.* filed jointly in *McRae v. Harris* and *Williams v. Zbaraz*, at 14-29.

A.195.) Moreover, drugs to treat the clotting are dangerous to the fetus. (A.195.) Although her doctor felt an abortion was medically necessary, she could not certify that Jane Doe's life would be endangered if the pregnancy were carried to term (A.195.) Slip op. at 96-7.

Plaintiff Doctor Bingham described a 16-year-old mother of two with rheumatic heart disease. Although he felt her pregnancy would aggravate the condition, it would not threaten her life. Slip op. at 111. Another member of the plaintiff class, from Minnesota, patient "X", was 18 when her doctor applied for a Medicaid abortion for her in December, 1977, under Minnesota's 1977 Hyde standard.[38] (A.114.) Patient X is and was a victim of juvenile rheumatoid arthritis, and had been so incapacitated she had been tutored at home her last two years of high school. In 1977, she had had a child by caesarean section and had been incapacitated during most of the pregnancy. Patient X was on several drugs for her arthritis, at least one of which is contraindicated during pregnancy. (Hodgson Aff., 1/4/78, A.119) Despite letters from two doctors and an evaluation from the Mayo Clinic, her abortion request was denied. (A.116.)

Another plaintiff, Susan Roe, was 19 when she became pregnant, only four weeks after having had her first child. Although her doctor felt that an abortion was medically necessary for both mental and physical reasons, since the short interval between pregnancies increases risk of premature labor or low lying placenta, the doctor could not certify her under either the life

[38] No pseudonym was used by this class member, whose case and supportive documents are in Appendix at 113-21.

endangering or the severe and long-lasting physical health damage standard. (Hodgson, A.122, 127.)

Diabetes is another condition which, if uncomplicated, is possible to treat, but which requires a complete evaluation of the total environment of the woman. A report by the British Medical Association on indications for termination of pregnancy concludes: "In a woman with severe diabetes who already has two or more children, increase in family responsibilities through further pregnancies will complicate seriously the proper control of her diabetes." (Pl. Exh. 3, p. 173-4/T. 55.) Although a diabetic woman is not likely to die from pregnancy, on the average, each pregnancy potentially shortens the life of a severe diabetic by five years. (Hodgson, T. 66.) Dr. Eliot testified about a Medicaid patient, a 14-year-old deaf woman with juvenile diabetes. (A.165.) Because of the increased risks due to her diabetes and age, Dr. Eliot regarded the abortion as medically necessary but not certifiable under the Hyde life endangerment standard. (A.165-66.)[39]

Cancer is another condition where an abortion may be medically necessary, but there is debate as to whether pregnancy would actually endanger the woman's life. Slip op. at 105-06. It is clear, however, that chemotherapy and radiation therapy have to be stopped since they damage the fetus.[40] Slip op. at 106. (Rothchild, T-804; Pl. Exh. 3, p. 174/T. 55.)

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[39] One possible complication from diabetes aggravated by pregnancy is blindness, which had happened to one of the witnesses' patients. (Hodgson, T. 87.)

[40] Brief of *Amicus Curiae* Planned Parenthood Federation of America, *et al., Williams v. Zbaraz* at 16.

Another common problem is presented by women who become pregnant with an intrauterine device ("IUD") in place.[41] If pregnancy continues, the risk of death from a spontaneous uterine infection, while still statistically small, increases 50-fold. (Pl. Exh. 213, p. 41.) Slip op. at 104. If it occurs, generally late in pregnancy, it is overwhelming and usually untreatable; a patient may die within 48 hours. (Hodgson, A.197.) Seventeen women died from this between 1972 and 1974. (Pl. Exh. 16, p. 5/T.970-71.) The Food and Drug Administration has issued regulations directing that abortion be offered as an option when pregnancy occurs with an IUD in situ and removal is difficult. 21 C.F.R. §§ 310.502, 801.427. (Hodgson, A.196.) HEW has made this same recommendation. (Pl. Exh. 213, p. 42.) All witnesses agreed that in such instances abortion is medically necessary, and in fact approximately two-thirds of the pregnancies occurring with an IUD in the uterus have been terminated by first trimester abortions. (Pl. Exh. 16, p. 5/T. 970-71.) However, because it is impossible to predict what would happen to any particular woman later in her pregnancy, doctors cannot certify women with IUD's in place under the life endangerment standard.[42] Slip op. at 104, 110. (Eliot, A.164.) Doctors are therefore placed in the professional dilemma of being required by federal regulation to tell their Medicaid patients that, although

[41] Pregnancy occurring with use of an IUD is not uncommon. One study found 8-12% of women became pregnant during the first year of IUD use. (Pl. Exh. 27, p. 140/T.1567.)

[42] Dr. Eliot testified, "I would have to classify such a case [pregnancy when the IUD cannot be removed] on a statistical basis as preserving her health rather than an imminent threat of danger to her life if she continued the pregnancy." (A.164.)

abortion is the recommended treatment, it will not be a covered medical procedure.

Malnutrition (slip op. at 102, Pl. Exh. 3/T.55); anemia (slip op. at 102, 108); heart disease (Pl. Exh. 3, p. 171/T.55); sickle cell anemia (slip op. at 108); cancer (slip op. at 105-06, Pl. Exh. 3, p. 174/T.55); urinary infections (slip op. at 107); phlebitis (slip op. at 104-05); and benign tumors (slip op. at 106-07) are all tions which, depending on a woman's total circumstances, including her motivation and cooperativeness, may make an abortion medically necessary.[43] Another important example is hypertension. Although three out of four hypertensive women can have successful pregnancies (Pl. Exh. 3, p. 172/T.55), the disease itself, even after treatment, entails a seven times higher risk of developing pre-eclampsic toxemia—one of the leading causes of maternal mortality. (Pl. Exh. 3, p. 172/T.55; Sloan, A.173; Romney, T.3968.) The trial court found that physicians cannot certify any of these complications of pregnancy for abortion under the life endangerment or severe and long-lasting physical health damage standards in the 1978 and 1979 Hyde Amendments,

> . . . because of the special nature of the life and health risks that all pose in some degree of their occurrence, and at some stage of gestation. The supporting data for safe certification cannot be at hand at the time when professional judgment would approve a termination of the pregnancy as "medically necessary," as that term is understood in the medical profession. Slip op. at 110.

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[43] The trial court gave examples of physical conditions that can become life threatening, but which cannot be predicted early in the pregnancy:

(footnote continued on next page)

b. Emotional and Psychological Factors Cause High Risk Pregnancies.

Plaintiffs presented uncontested evidence about the devastating psychological and emotional effects unwanted pregnancies have on many women, and which may make abortion medically necessary.

The trial court found that the evidence demonstrated

> the impact of unwanted pregnancy on mental health, both in gravely aggravating mental ill health that existed before the pregnancy, and in producing severe mental disturbance, including suicidal ideation, in the case of patients in trying life circumstances who are already near the limits of endurance. Slip op. at 116.

But the Hyde Amendments do not authorize abortion to avoid even certain and serious and long-lasting psychological damage.[44]

Pregnancy can aggravate myoma: if the tumor grows beyond the vascular supply needed to keep it benign, the tumor may become necrotic and produce peritonitis, abscess formation, infection and so become life-threatening. Urinary tract infections, too, are not uncommon, but, Dr. Romney testified, the possibility of an ascending urinary tract infection is increased during pregnancy; if it remains a mild cystitis, that is, a localized bladder infection, it may not be dangerous; but if a virulent infective organism produces a severe cystitis, that can develop into a renal abscess, and, in a patient with a large pregnant uterus, prevent proper drainage, seriously threaten control of the infection and so jeopardize the woman's life. Slip op. at 107.

[44] Congressional debate surrounding the adoption of the 1978 and 1979 Hyde Amendments, which allowed for "severe and long-lasting physical health damage," makes clear that all mental health concerns were to be excluded. Slip op. at 123; Annex to slip op. at 236, 244, 247.

Plaintiff Ann Moe was 15 when she applied for a Medicaid abortion in January, 1978. She had spent most of the preceding three years in adolescent psychiatric wards and correctional institutions, and was diagnosed schizophrenic. Dr. Hodgson believed an abortion was medically necessary because not only was the patient at higher physical risk due to her youth, but also continued pregnancy would result in serious mental health damage. Yet she could not certify Moe under the Hyde Amendment. (Hodgson Aff., A.113.)

Although an unwanted pregnancy is stressful for anyone, for the psychiatrically disturbed the danger of breakdown is greater, and patients who are under treatment can become psychotic and regressed, particularly if medication is discontinued because it may cause a developmental defect in the fetus.[45] Slip op. at 119. (Belsky, T.3520-21.)

One Medicaid patient whose pregnancy threatened her recovery was a 33-year-old mother of three children who was hospitalized in a state mental hospital. (Eliot, A.162.) She got pregnant on a weekend furlough, despite using a diaphragm. Although she obtained a Medicaid abortion and her mental health continued to improve, her doctor testified that he would not have been able to certify her under the life endangerment standard.[46] (Eliot, A.163.) Another woman,

[45] One study of 21 women hospitalized in a psychiatric ward found that the vast majority reporting an unwanted pregnancy felt continuing it and caring for children had contributed to their decompensation. Grunebaum, et. al., The Family Planning *Attitudes, Practices and Motivations of Mental Patients*, 128 Amer. J. Psychiatry, 470 (1971). (Pl. Exh. 160/T.3633.)

[46] Another example of a woman whose pregnancy represented a set back in her mental health was 19 when she applied for an abortion. From the age of 12 to 16 she had had an incestuous

described by her psychiatrist as "paranoid schizophrenic" (Pl. Exh. 159/T.3601, A.280.) became psychotic because of her unwanted pregnancy, and exhibited physical symptoms such as constant vomiting, causing a weight loss of 18 pounds. Another woman who was retarded, had four small children she could not cope with and thought of burning herself and them up. The thought of another child led her to attempt jumping from the roof. (Pl. Exh. 156/T.3590, A.278.) She obtained an abortion because her doctor described her as suicidal and homicidal, but it is not clear that she could be certified under the Hyde standard.

The trial court made findings, overwhelmingly supported by the evidence, that for some women the unwanted pregnancy itself can produce severe psychiatric problems.[47] Slip op. at 120-22. Medicaid-eligible women are more exposed to stress, and thus more susceptible to mental illness caused by stress, than are others.[48]

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relationship with her father. At 16 she became pregnant, delivered a baby at home alone, and threw it in the garbage. She began using heroin to alleviate her guilt and depression. With psychiatric treatment in a residential center, she was able to improve to the point that she started college. As a result of her new unwanted pregnancy, her mental health started to deteriorate, with serious feelings of guilt and self-hatred. (Pl. Exh. 151/T.3594, A.273.)

[47] The President's Commission on Mental Health, Subpanel on Mental Health of Women underscored the issue of reproductive freedom "because of particular importance to the prevention of mental disorders among women" (p. 1078) and recommended Medicaid funding for abortion be resumed (p. 1099). (Pl. Exh. 257.) Slip op. at 121.

[48] Dr. Belsky described one woman who developed an anxiety neurosis because of all the rats in her dilapidated apartment. Despite her efforts at cleaning, there were rats and rat feces all over. Her five-year-old son could not sleep by himself because he was so frightened. (T.3623, A.186.)

(Belsky, A.185.) For one woman with three children whose husband had been murdered the month before she discovered she was pregnant, the pregnancy was the breaking point.[49] (Pl. Exh. 159-c/T.3601, A.283.)

It is very difficult for doctors to assess threats of suicide (Eliot, T. 484), and applications on that ground under the pre-1973 criminal abortion statutes were largely approved only for private patients. (Pl. Exh. 142/T.3529; Pl. Exh. 143/T.3529; Belsky, T.3533; Tietze, T.989-90.) Slip op. at 85-6. Yet it is equally clear that the stress of an unwanted pregnancy makes poor women all the more desperate. (Belsky, A.187.) Threats to their lives, either by suicide or by dangerous self-abortions, have been and continue to be common.[50]

Although doctors would probably be able to reach a consensus on an evaluation of the effect of an unwanted pregnancy on a particular woman's mental health, a certification that her life would be en-

[49] Plaintiff Mary Doe, at the time of her abortion application, was a 19-year-old Connecticut woman who had four small children. Her doctor testified that she was so desperate about her pregnancy that if she could not get a legal abortion, she would try to abort herself and risk permanent damage. Even if he would do the abortion she was in the second trimester and could not be admitted to the hospital without prior medical approval. (A.182-83.) Dr. Bingham did not think he could certify her under the Hyde standard. (A.107-08, 183.) However, he could certify her under a standard of medical necessity. (A.183.)

[50] One unpublished study by Dr. Belsky consisted of interviews and follow up of 90% of the poor women who got abortions at Bellevue Hospital in 1969-70. (Pl. Exh. 144/T..3538, A.267.) Before the Therapeutic Abortion Committee was abolished, out of 204 patients, 77, or 37.7% attempted either an illegal or self-induced abortion. (Pl. Exh. 147/T.3554, A.269.), and 23 out of 204 or 11% tried to commit suicide (Pl. Exh. 148/T.3554, A.270.) Before abortion was legalized, nationally about 18% of all maternal deaths were due to abortion. In 1965 there were 235 deaths. Slip op. at 10.

dangered would arbitrarily depend on a doctor's view of whether to cerify what is statistically a remote possibility, at least for a general population. (Eliot, A.161-63; Hodgson, A.68-68a, 112, 146; Romney, T.1124-25, 3970-71; Pisani, T.2216; Tietze, T.899; Belsky, T.3532.) *See* Slip op. at 123.

Medical studies document that being forced to continue an unwanted pregnancy can be a major factor contributing to mental illness in women.[51] A woman's psychological and emotional response to an unwanted pregnancy causes physical risks, just as mental or emotional factors can cause such symptoms as asthma or ulcers. (Sloan, A.170.) Aside from suicide and self-abortion attempts, both unquestionably risky to health and life, other psychosomatic illnesses occur, such as hyperemesis, excess vomiting so severe as to require hospitalization.[52] (Sloan, A.168; Pl. Exh. 159/T.3601, A.280.) *See also* slip op. at 109-10.

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[51] A British study comparing women who requested an abortion and were turned down with those who were permitted to terminate their pregnancies concluded: ". . . the stress of bearing an unwanted child can lead to psychiatric symptoms. In our series such symptoms were not uncommon, were sometimes protracted and were occasionally severe enough to require admission of the patient." The study also found that "patients in whom pregnancy was terminated on our recommendation had remarkable little psychiatric disturbance." Pare, *et. al.*, *Follow-Up of Patients Referred for Termination of Pregnancy,* The Lancet, March 28, 1970, (Pl. Exh. 162, pp. 637-38/T.3633.) *See also,* Romney, T. 1121-23, 3940, 3945; Belsky, T.3618, 3689-91. Slip op. at 143-44.

[52] Dr. Sloan, Director of Psychosomatics in the Department of Obstetrics and Gynecology at New York Medical College, defined a psychosomatic condition as an "organic symptom that has manifested itself in its causation or etiology in the psyche or mental aberration." (Sloan, A.170.)

Hypertensive states of pregnancy, a leading cause of maternal mortality (Sloan, A.172.), is known to be exacerbated or caused by stress.[53] Another not uncommon symptom is excessive starch intake which in turn causes severe anemia. (Sloan, A.169.) Childbirth itself can become much more dangerous when the pregnancy is unwanted.[54] In describing the impact of unwantedness, the trial court, relying on Dr. Romney, stated:

> [T]he prognoses for wanted and unwanted pregnancies are different, and that the woman's failure in attitude, cooperation and motivation can result in the evolution of potential complications into reality; . . . labor of women whose pregnancies were unwanted was almost physiologically different from normal labor, and that the apprehensive, tense unwanting woman adjusted poorly to the delivery room, her tensions stimulating, experimental data suggest, the production of epinephrine (a hormone secretion of the adrenal gland) which inhibits the uterine contraction. Slip op. at 112. (T.1084.)

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[53] Testimony related a statistical analysis showing a much higher incidence of preeclampsia (hypertension) among women who were seen in the psychosomatic clinic at Flower Fifth Avenue Hospital in comparison with other obstetrical patients. (Sloan, A.173.)

[54] Several witnesses testified that they had delivered babies for women at various Florence Crittenton Homes for Unwed Mothers, where there was a higher incidence of abnormal labor and caesarean sections. (Romney, T.1060-61; Sloan, A.174-75.)

c. **Most Pregnancies Caused by Rape and Incest Are not Covered by the Hyde Amendment.**

The 1977 Hyde Amendment specifically excluded federal funds for pregnancies resulting from rape or incest. Subsequent versions, as interpreted in HEW regulations, allow reimbursement only if the crime is reported within sixty days. 42 C.F.R. 441.205(a)(3) (1978).

Uncontested evidence proved that incest is alarmingly common, that incestuous relations usually continue over a period of time, and that the child victims are unlikely to report the crime promptly. Slip op. at 155-57. Pregnancy occurs in 20-25% of the reported cases of incest. (Sarles, T.3752.)

The trial court found that most pregnant rape victims are effectively denied Medicaid abortions because:

> The very young, those in fear of retaliation, those inhibited by a natural revulsion from recounting what happened, and those who fear unsympathetic and uncomprehending treatment by the authorities tend not to report rape to law enforcement agencies or to public health services. Slip op. at 151.
>
> Similarly with regard to incest, the trial court found:
>
> In the case of incest, the 60-day report requirement is inherently likely to restrict the availability of funding to a minor fraction of the total number of cases. Slip op. at 156-57.

The devastating effects of unwanted pregnancy resulting from rape or incest were undisputed. *See* slip

op. at 151-57.[55] The data on certifications under the Hyde Amendment make plain that only a very small proportion of poor women, pregnant as a result of rape[56] or incest, have met the requisite reporting requirements for a federally funded abortion. Slip op. at 59, 151.

d. Familial Considerations, Including the Effect of Diagnosed Fetal Deformities, May Make Abortion Medically Necessary.

Familial considerations are part of a doctor's total evaluation of the effect of a woman's pregnancy on her health. They are also a consideration in whether a woman can follow an alternative form of treatment, such as bedrest. Dr. Eliot described a Medicaid patient who was pregnant because of contraceptive failure. She was 30 years old and had two mentally retarded children. She wanted an abortion because she feared

[55] The mental strain on incest victims is aggravated by the fact that their offspring have a high likelihood of deformity and/or death, even if the parents are normal. The only available study (Sarles, T.3765) shows that out of 18 children of incest, 11 died or suffered some deformity, including spastic cerebral palsy, cleft palate, and mental retardation. *See* Pl. Exh. 167, Adams, *et. al.*, *Children of Incest*, Pediatrics, Vol. 40, No. 1, July 1967, p. 59.

In the case of unwanted pregnancy resulting from rape, abortion is the preferred medical treatment to prevent possible suicide or drug use by the victim in an effort to rid herself of an unreasonable sense of guilt and self-punishment mixed with the desire to be rid of the product of the assault. Slip op. at 153-54. (Bard, T.1274.)

[56] Victims of statutory rape, such as plaintiff Ann Moe, are unlikely to report the act. (Ann Moe Aff. ¶ 1, 5, A.125-26; Hodgson Aff., 1/4/78, ¶ 3, 4, 10, A.113-14.) Testimony showed that teenagers, because of menstrual irregularities and ignorance, are unlikely even to know they are pregnant within 60 days of intercourse. (Romney, T.3974.)

her next child would also be retarded, and because she did not believe she could cope with the burden of an additional child, even if it were normal. Dr. Eliot testified that although he believed abortion was medically necessary for this woman and necessary for "her family's mental and physical health . . . [i]n no way was her life endangered by her pregnancy." (A.163.) Slip op. at 118.

Family circumstances can be so overwhelming[57] that not only the woman's health, but the health of her children is at stake.[58] (Pl. Exh. 159/T.3601, A.280.) Witnesses testified to patterns of child abuse exacerbated by an additional pregnancy.[59] (Belsky, T.3582-83, 3591-92.)

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[57] One witness described a patient who had eight living children ranging from 2 to 19 years old. A ninth child died in an accident. The 19-year-old, who was severely retarded and epileptic, was unable to walk or speak. The 17-year-old had been emotionally disturbed since age four and beat his mother and siblings. The 6-year-old had a heart murmur; the 5-year-old had a congenital cardiac condition which required surgery; the 4-year-old was asthmatic; and the 2-year-old has bronchitis. Mrs. "X" had been on tranquilizers and was overwhelmed by the burdens of her unwanted pregnancy. (Belsky, T.3572; Pl. Exh. 1501/T. 3576-77, A.171-72.)

[58] Several witnesses spoke of situations of child abuse where their patients had unwanted children, repeating a cycle of such abuse when the patient had been abused as a child. (Belsky, T.3581-83, 3590-93; Slip op. at 219-30) Plaintiff Susan Roe, 19 years old, single and pregnant again when her child was 4 weeks old, swore in her affidavit that "I am fearful of becoming an abusive parent, like some of my friends, if a second pregnancy is forced upon me." (Susan Roe Aff. ¶ 2,3,6, A.123.)

[59] One poor woman seeking an abortion was thus described by her psychiatrist: "She was becoming very irritated every time the baby cried and she had done 'bad things' to her baby. The baby was nine months old. The bad things she did was to tie a rag around the baby's mouth when she cried to muffle the noise,

The trial court found that unwanted children born to women denied abortion suffer predictable disadvantages. Slip op. at 126. This conclusion was supported by the uncontested testimony of the medical witnesses and several controlled studies. Slip op. at 126-30. (Pl. Exhs. 161/T.3633, 163/T.3633; Belsky, A.187-90.)[60] HEW has recognized the correlation between abuse and the stress of poverty and unwanted childbearing. (Pl. Exh. 282, p. 25.)

Another familial consideration is the doctor's evaluation of the effect a severely deformed child will have on a woman and her existing family. Both the degree of risk and the nature of the defect are factors traditionally considered by doctors in advising their patients whether an abortion may be medically necessary.[61] The enormous life-long impact of having such a child on the mother and the entire family is

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which is, incidentally, very dangerous and can cause suffocation." (Belsky, T.3582, Pl. Exh. 152/T.3582, A.275.)

[60] A ten year study of 440 children born to women who had sought and were denied abortions and who had not aborted, concluded that the children born into this "potentially handicapping situation", suffer many disadvantages:

> The higher incidence of illness and hospitalization despite the same biological start in life, slightly poorer school marks and performance despite the same level of intelligence, somewhat worse integration in the peer-group—all these point to a higher-risk situation for the child and the family, as well as for society. Dytrych, *et. al.*, *Children Born to Women Denied Abortion*, 7 Family Planning Perspectives 165 (1975) (Pl. Exh. 161, p. 171/T.3633.) *See also*, Forssman, *et. al.*, *One Hundred and Twenty Children Born After Application for Therapeutic Abortion Refused*, 42 Alta Psychiatrica Scandinavia 71 (1966), Pl. Exh. 163, p. 87/T.3633; Belsky, T.3633.

[61] *See Indications for Termination of Pregnancy*, a report by the British Medical Association, Pl. Exh. 3/T. 55.

undisputed.[62] Slip op. at 162. (Belsky, A.192; Tietze, A.201-05.)

The Hyde Amendments preclude abortions that are medically necessary because of fetal abnormalities. Slip op. at 30-1, 130. The trial court found that this absolute exlusion—"no matter how grave the abnormality nor how great its threat to the stability of the existing family . . ."—was one of the many ways in which the Hyde standard is even narrower than that legally available to women under the pre-1973 criminal abortion laws.[63] Slip op. at 130, 162.

The record shows that, to a certain extent, amniocentesis can predict fetal abnormality. It is now possible to diagnose chromosomal defects in the fetus.[64]

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[62] Dr. Belsky described the intense suffering of one of her patients who was pregnant and who had two genetically defective children.

> [S]he was not schizophrenic but she was very depressed. She wanted very much to have a normal child. She described her experience with these two children. Liber syndrome is a severe disorder of the central nervous system and her babies were both blind and severely retarded, unable to recognize another human being, unable to sit up, talk or walk. One of them lived to be four and one lived to be two and a half and essentially they were vegetables. There was no meaningful existence, really, for these children or any maningful relationship with anybody else.
>
> I think the only reason they lived was because of her devoted care. They eventually died of pneumonia. . . . [S]he made the suicide attempt following the death of one of the children when her husband [and his] family blamed her for the disease and death of the child. (A.190-91.)

[63] A few states which adopted the Hyde standard explicitly added a category of state funded abortions for fetal deformities: Iowa, Maryland, and California. *See* n.14, *supra*.

[64] In 1974, 3,000 women used a test, amniocentesis, performed at 16 weeks of pregnancy, which identifies with 99.4% accuracy

(Tietze, A.205.) Scientific knowledge about damage to fetal development caused by drugs is growing. (Belsky, T.3620; Eliot, T.470.)

Even though rubella seemed not to qualify under the old New York life-saving abortion statute, doctors stretched the law to include these abortions. A woman who contracts rubella or German measles early in pregnancy faces an 80% risk that her child will be seriously defective. (Pl. Exh. 3, p. 175/T.55.) In New York City in 1964, the year of a rubella epidemic, 57% of abortions were for this reason.[65] (Pl. Exh. 10, p. 1/ T.890.)

One type of abnormality which can be identified with certainty through amniocentesis is Tay Sachs disease. One out of every 15 Jews of Eastern European descent is a carrier. The children suffer and die a certain death. Dr. Tietze described the progress of this disease:

> The children are born normal. In fact it is said that they are particularly beautiful children and they seem to develop quite normally, but at six or nine months, things change . . . [at] 12 to 18 months the child is blind as well as completely

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all recognized chromosomal abnormalities. (Pl. Exh. 263, p. 147.) That test is much more common today. Slip op. at 132.

[65] The rubella experience demonstrates the arbitrary enforcement of the pre-liberalization standards. The ratio of therapeutic abortions for rubella to 1,000 live births at private service hospitals from 1960-62 was .40 while at municipal hospitals it was only .03. (Pl. Exh. 10/T.890.) In Minnesota, which had a life-saving standard similar to New York (Minn. Stat. Ann. Penal Code § 617.18), Dr. Hodgson had been prosecuted and convicted in 1970 for performing an abortion on a woman who had contracted rubella. (T.39-40.)

> paralyzed, but he usually continues to live for another few years. They are all dead by five years of age and preceding that, they have to go through a period where they require the most intensive care . . . . Eventually they . . . have convulsions which may come as often as every hour. It's an enormous problem, financial and emotional, for the parents as well as . . . a most miserable way of dying for the child. (A.202-03.) Slip op. at 132-33.

e. Poverty Is an Additional Factor Which May Be Medically Significant.

Although poverty alone does not make abortion medically necessary, the trial court found that "poverty is medically significant." Slip op. at 101. Physical and mental illnesses are more common among the poor. Slip op. at 101-02. (Bingham, A.184; Belsky, A.185; Eliot, T.407; A, Tietze, T.991,999.) It has also been proven statistically that maternal mortality is much higher among the non-white population.[66] Slip op. at 103. (Def.-Int. Exh. H, p. 17/T.2227.) The trial court found:

> The pregnant woman's poverty, both as it affects her general health and denies her the means of

[66] In 1972, the rate of maternal mortality for non-whites was 490% higher than for the corresponding white population. The difference declined until 1975 when the rate for non-whites was 76% greater than for white females. In 1976, the rate rose again to 327% higher than white females. (Def.-Int. Exh. H/T.2227, A.304.) As 39% of black women rely on Medicaid for their health care needs, compared to seven percent of white women, and the abortion to live birth ratio is nearly two times higher among blacks than whites, the health of black women will be disproportionately affected by the funding restrictions. (Pl. Exh. 24 p. 213/T.1534.)

> dealing with her pregnancy and its special problems and restrictions, increases her risks of health damage, and even of mortality, from the diseases and conditions that cause complications in the pregnancies of women generally. Slip op. at 103.

Poor women also have less access to alternative treatment for high risk pregnancies. Bed rest may be impossible for poor women who cannot afford either to leave their jobs or to pay for help with their chores or chldren. (Romney, T.3966; Pisani, T.2214-15.) *See* Facts, *infra* § 8.

f. Teenage Pregnancy and Childbearing Pose Significant Risks.

The trial court found that:

> Pregnant teenagers, particularly the younger teenagers, are a disadvantaged class, recognized by Congress; they are disadvantaged by the convergence in their unwanted pregnancies of physical and psychological immaturity, poverty and dependence, and a high risk of serious pregnancy-connected physical and psychological complications that threaten permanently to undermine the health of the pregnant teenagers and their fetuses. . . .No legislative interest outweighing the interest in the teenagers' health can be advanced to justify the discriminatory denial of necessary medical care. Slip op. at 315-16.

All of the problems created when a poor woman is denied Medicaid funding for abortion are magnified for poor pregnant teenagers, who accounted for one-third of Medicaid abortions before the Hyde Amendment took effect. (Hofmann, T.1332; Pl. Exh. 21/R.110.) In

1976, the HEW Office of Child Health Affairs concluded that teenage pregnancy is "one of the most if not the most pressing health problem of individuals 19 years of age and under." A 1978 HEW Task Force report found it to be a "major public health problem with serious medical health, education, social, psychological and vocational implications for the mother and baby." [67] Slip op. at 134. (Pl. Exh. 253, p. 1.)

According to a study prepared by HEW in 1977 (the "Shuck Memorandum"), approximately 300,000 adolescents receive abortions annually—one half under the age of 17. Approximately 85,000 of these teenage abortions were funded by Medicaid. Slip op. at 135-36. (Pl. Exh. 244, p. 1.)

A recent comprehensive study of adolescent health found the consensus of medical experts to be that: "Girls are at increased risk biologically and emotionally if pregnancy occurs before they complete their own physical growth." Slip op. at 134-35. (Pl. Exh. 20, p. 17/ T.1317; Hoffmann, T.1368.) Dr. Hofmann, the former President of the Society for Adolescent Medicine, testified that she would consider pregnancy "a pathological condition—in a broad definition of the word pathological . . . (physiologically) for the young group and emotionally for the total adolescent group." (T.1435-36.) Slip op. at 141-42.

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[67] Teenage pregnancies now account for a larger proportion of all births in the U.S. than ever before. Menken, "The Health and Demographic Consequences of Adolescent Pregnancy and Childbearing," 1977, (hereafter "Menken, 1977"), (Pl. Exh. 241, p. 1.) Although overall birth rates have declined, teenage birth rates have risen. Birth rates of girls 17 and under have risen particularly sharply. Between 1968 and 1973, the number of such births rose 25%. In contrast, during the same period total births *decreased* 10%. *Id.*

Fatal complications in pregnancy are 60% more likely for a girl under 15 than for a woman 20-24, and 13% more likely between the ages of 15 and 19. Slip op. at 137. (Pl. Exh. 21, p. 23/R.110; Hofmann, T.1346a.) Compared to women 20-24 years old, 15-19 year-olds can be twice as likely to suffer fatal complications as a result of hemorrhage, spontaneous abortion or toxemia. Under 15 they are 3.5 times more likely to die from toxemia. Slip op. at 137. (Pl. Exh. 21, p. 62/R.110; Hofmann, T.1346-48.)

The risks of severe but non-fatal complications of pregnancy, many of which permanently impair the young woman's future life, health, and reproductive capacity, are also significantly higher for teenagers.[68] HEW reports that "studies show pregnant adolescents have higher rates of toxemia, prolonged labor, premature delivery, pelvic disproportion, and Caesarean section than more mature women. Slip op. at 135. (Pl. Exh. 20, p. 17/T.1317; Hofmann, T.1345.)

The increased health risk to the adolescent can be partially attributed to her lack of physical maturation. Slip op. at 141-42. (Hofmann, A.210-11.) Dr. Hofmann testified that pregnancy during the critical growth period of puberty can actually impede physical growth, even if there are no complications. Slip op. at 144, 147. (Hofmann, A.211.)

Teenagers are further at risk in pregnancy due to their special vulnerability to specific health hazards.

[68] The increase in complications is enormous. For every 100 women between 20-25 who suffer toxemia or toxic anemia, 131 teenage girls will be afflicted by toxemia, 125 teenage girls will suffer from anemia for every 100 of the older group; and 113 teenagers will develop infections at the time of delivery for every 100 of the older group. (Pl. Exh. 21, A.260; Hofmann, T.1344.)

The Schuck Report summarizes some of those health problems to which teenagers are particularly sensitive:

> While adolescents are often characterized as a healthy group, they experience problems such as venereal disease, drug and alcohol abuse which threaten their well-being. The incidence of gonorrhea in adolescents at 15-19 is second only to those 20-24. In one national sample, 13.7 percent of adolescents reported that they were moderate to heavy drinkers—the same percentage as adults. (Pl. Exh. 244, p. 3.) *See also* slip op. at 138.

For poor pregnant teenagers, like their older counterparts, the jeopardy is even greater because poverty breeds poor health. *See infra* Section 5e. Moreover, health care services are not generally available to adolescents.[69] The trial court found, based on expert testimony and HEW documents that even the best prenatal care "has not been able to reduce adverse consequences of pregnancy to the same level as for older women . . . " (Pl. Exh. 244, p.4.)

The impact of pregnancy on adolescents is further compounded by the high incidence of rapid repeat pregnancies—about 44% of adolescents having first babies will have second pregnancies within a year.[70] Slip

[69] Teenagers are often unaware of their pregnancy because their menstrual cycle is irregular and they do not seek medical care until gestation is advanced. Slip op. at 142. (Hodgson, T.489-90; Romney, T.1140.) Fifty percent of adolescents receive no prenatal care in their first trimester; 10% do not receive any prenatal care before the third trimester. Slip op. at 142. Even those who do see physicians early in pregnancy find it difficult to comply with their doctor's suggestions regarding prenatal care. Slip op. at 143. (Hofmann, T.1343-44.)

[70] Plaintiff Mary Doe is 19 years old, and the mother of four children. She bore her first child at 14. (Doe Aff.,¶ 3, A.105.) The

op. at 136. Children born of adolescent mothers have a higher rate of infant mortality.[71] Furthermore, the trial court found that "children born of adolescent mothers are more likely to be premature and susceptible to birth defects, including mental retardation."[72] Slip op. at 162-63.

The trial court found "that teenage pregnancy imports high psychological stress for the adolescent." Slip op. at 144. Moreover, pregnancy and the profound responsibility of parenthood before the individual's emptional and psychological maturation process is complete can retard the young adolescent's achievement of full maturity. Slip op. at 143-44. (Hofmann, A.212-13.)

Depression is one of the primary symptoms, among "a host of serious emotional problems that occur with an unwanted pregnancy." (Hofmann, A.213.) One study revealed that there is a high correlation between unwanted pregnancy and suicide attempts by teenagers actually, or believing themselves to be, pregnant. (Pl. Exh. 23, p. 136/T.1377; Hofmann, A.213-14.)

HEW Report on Teenage Pregnancy states that the adverse effects of teenage pregnancies are multiplied when the second pregnancy occurs before a woman has reached 20 years of age. (Pl. Exh. 253, p. 6.)

[71] About six percent of first babies born to girls under 15 die in their first year, a rate 2.4 times higher than babies born to women in their early 20's. Babies born to 15-year-olds are twice as likely to die than babies born to mothers aged 20-21. (Pl. Exh. 21, A.260.) High mortality rate is related to prematurity, infection, and sudden infant death syndrome. (Hofmann, T.1356.)

[72] Low birth weight, a measure of prematurity, occurs with much greater frequency in infants of teenage mothers. Dr. Hofmann described it as the "single greatest risk to the fetus." (T.1351.) Prematurity is linked not only to high infant mortality but to neurological problems like epilepsy, brain damage, cerebral palsy, and mental retardation. Slip op. at 139-40.

For teenagers with pre-existing psychiatric illness such as 15-year-old plaintiff Ann Moe, unwanted pregnancy may lead to psychosis and, in addition, may preclude complete recovery forever. (Hodgson, Aff. 1/4/78, R.99, ¶ 1,7,8.)

For other teenagers, like plaintiffs Mary Doe and Susan Roe, an unwanted pregnancy, if not terminated, may be the factor which transforms a precarious and difficult life into one with which they are unable to cope either physically or mentally.[73] (Doe Aff., A.105-06; Roe Aff., A.123-24.)

6. The Hyde Amendment Is Impossible for Physicians to Apply, and Precludes the Exercise of Medical Judgment.

Both the original Hyde Amendment and the one in effect when the district court rules both required physicians to determine that the life of the pregnant woman "would be endangered if the fetus were carried to term." The trial court, concluded:

> The medical testimony requires the finding of fact that the life endangerment standard . . . is not a term used in the medical profession as a standard for determining medical procedures, and that it is not susceptible of any agreed definition among medical practitioners. Slip op. at 91.

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[73] Psychological problems are aggravated by the social and educational effects of teenage pregnancies:

> Surveys indicate that between one-third and one-half of all adolescent females who drop out of school do so because of pregnancy or marriage. Early parenthood is a major reason for males to drop out of school.
>
> Adolescent parents run higher risks of unemployment and welfare dependence than those who delay their first child until their twenties. (Pl. Exh. 244, pp. 1-2.)

The court further found that:

> Restricting abortion alone of all medical procedures, to the life endangerment circumstance has no support in any medical evaluation of medical conditions and the medical procedures appropriate to the medical conditions; the physicians who reject all direct abortion do so on grounds other than a medical evaluation of condition and procedure. Slip op. at 320-21. *See also*, slip op. at 310.

Medical witnesses testified that this standard is both alien to the practice of medicine today[74] (slip op. at 91; Tietze, T.922; Hodgson, A.195-96; Romney, T.1063), and impossible to apply in the context of pregnancy. (Romney, A.217; Eliot, A.164; Hofmann, A.206-07.) They agreed that, with advanced technology and supervision, it is possible for women with life threatening conditions to survive pregnancy.[75] Slip op. at 90. However, ". . . the testimony rested on the assumption that the pregnant woman was desirous of bearing the child and was cooperative throughout the pregnancy." Slip op. at 91.

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[74] The trial court found that the additional standard in the 1978 and 1979 Hyde Amendments "severe and long lasting physical health damage" adds no "added class of definable instances" (slip op. at 100), and it was not terminology familiar to the medical profession, as proven by the extreme "anomalies in classification shown by the statistics" (slip op. at 101), and despite the fact that Congress intended to add a definable class. Annex to slip op. at 236-37.

[75] Medical experts estimated that fewer than one-tenth of one percent to one percent of women who wanted to have a child, and were willing and able to follow any regime, would have to have abortions. (Bingham, A.184.)

The medical witnesses emphasized that the prognosis of any particular pregnancy is complex in light of the numerous dimensions to the life endangerment concept (slip op. at 91), including: the degree of risk to the woman's life; the probability of its eventuation; the relationship of a patient's condition to the available resources; and the patient's behavior in terms of her having the means and will to carry out the medical program. Slip op. at 92.

They testified that, despite the potential scope of "life-endangerment" there would be a reluctance to certify under such an alien standard. In fact, the trial court found that the "life-endangerment" exception has been interpreted more narrowly than the pre-1973 standards. Slip op. at 96.

a. It is Not Possible to Know Early in Pregnancy Whether a Woman's Life Will Be Endangered.

As noted, the Hyde Amendment precludes physicians from exercising medical judgment to certify abortions under Medicaid for physical, mental health or familial reasons. Although Hyde permits funding for terminating pregnancies that endanger the life of the woman, even that standard precludes the exercise of medical judgment in practice, because it requires virtual certainty. Although doctors can often determine early in pregnancy that continuation of the pregnancy will substantially increase the *risk* of life endangerment they cannot ordinarily certify that pregnancy will in fact endanger life until late in pregnancy, when it is too late to avoid or control the life-endangering complications, or when abortion itself would be very dangerous. In effect, Hyde precludes preventive medical practice, even when medically necessary, and requires

the woman and the physician to wait until there is no room left for medical judgment.

The trial court found that:

> There is a very large number of specifically pathological conditions that at some level of intensity and under some circumstances of treatment will jeopardize the health or life of a pregnant woman and indicate termination of the pregnancy as the medically most appropriate procedure. However, except for a few classic conditions, they are not characterized by that certainty of predictability that the Hyde-Conte amendment and its successors appear to require; in large part the conditions do not assume their definitely life-threatening or health destructive intensity until so late in pregnancy that abortion is no longer a safe procedure. Slip op. at 161.

No medical expert thought it possible to predict life-endangerment with certainty early in pregnancy. Dr. Romney testified that, despite the greater diagnostic tools and statistical evidence to draw upon, early prediction is very shaky in individual cases.[76] (A.216-17.) *See also*, Pisani, T.2206-09; Hofmann, T.1400, 1433.

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[76] *See* Cates, *et al.*, *The Intrauterine Device and Deaths from Spontaneous Abortion*, New Eng. J. Pub. Med. 1155 (1976), reprinted by CDC, PHS, DHEW. (Pl. Exh. 213.) Doctors also questioned certifying, for example, patients with hypertension in stressful unwanted pregnancies who run a seven-fold risk of developing, late in pregnancy and despite treatment, pre-eclamptic toxemia, a leading cause of maternal deaths. (Sloan, A.173-74; Romney, T.3968-69.) On cross-examination of Dr. Hodgson, the United States Attorney suggested that she would have to monitor such a patient until she could say "she had a real chance of a fatal stroke or some other fatal condition." (T.70.)

Maternal mortality studies are important for two reasons.[77] First, they demonstrate that the leading causes of maternal deaths are conditions for which medical science cannot make the individual predictive judgments required by the Hyde Amendments. They also underscore the importance of legal abortions in reducing maternal mortality.[78] What they do not show are those deaths from pregnancy-related suicides and those deaths caused some time after childbirth by conditions aggravated by pregnancy and childbearing.

The studies show that throughout the 1960's and 1970's, the vast majority of maternal deaths were due to direct obstetric complications of pregnancy[79] as opposed to pre-existing diseases, aggravated by pregnancy or causes unrelated to pregnancy. (Def.-Int. Exh. M, p. 2; Def. Exh. J, p. 822/T.2227.) Hypertensive states of pregnancy—a leading cause of maternal mor-

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[77] These include: N.Y. Department of Health, *N.Y. State Maternal Mortality Study, 1970-76,* June 1977 (Def.-Int. Exh. H/T. 2227); Schaffner *et al., Maternal Mortality in Michigan: An Epidemiologic Analysis, 1950-75,* 67 A.J. Pub. Health 821 (1977) (Def.-Int. Exh. J/T.2227); *Minnesota Maternal Mortality Study, 1950-75* (Def. Exh. M); Data on Maternal Death, *Vital Statistics of the United States* (Pl. Exh. 261).

[78] Maternal mortality studies normally include deaths arising from abortion. In 1967, the total number of maternal deaths in the United States was 218. They declined to 157 in 1968, 154 in 1969, and 128 in 1970. In 1973, the year abortion became widely legalized, maternal deaths markedly decreased to 30. There were 24 in 1974, and 17 in 1975. The major factor in the reduction of deaths was the advent of legal abortions. Slip op. at 11. (Pl. Exh. 8A, p. 15.)

[79] "Direct maternal deaths" is the term used to describe obstetric complications of the pregnancy state or labor. "Indirect maternal death" occurs when pregnancy or labor is made fatal by an underlying condition such as diabetes *See* Def.-Int. Exh. H, p. 6, A.304; Def.-Int. Exh. J, p. 822/T.2227.

tality, and other conditions, do not arise until late in pregnancy.[80] The studies confirm the testimony of both parties' medical experts that it is impossible to make a definitive prediction early in pregnancy that a woman will or will not die from conditions which are the leading causes of pregnancy-related deaths.[81]

Predictability in the "large gray area" of borderline cases described by Dr. Romney and others, is virtually impossible. He described the unpredictability surrounding women "who are not totally healthy . . ., who have [an] acute or chronic disease" which is not of sufficient magnitude to clearly predict trouble. (T.1118-19.) Discussing the impossibility of predicting life-endangerment in the hypothetical case of a markedly obese woman seeking an early abortion, he said:

> I had no crystal ball which allowed me specifically to project the course . . . [the] pregnancy would

[80] A New York study of maternal deaths from 1970-76 shows that in each hypertensive state case, the condition did not appear until after the 20th week of gestation with the eclamptogenic process usually appearing later than the 25th week. A study of complete case records showed that even after death it was not possible to identify any prior medical history connected with the deaths of eight of the eleven women studied. (Def.-Int. Exh. H, p. 28/T.2227, A.306.) Defendant's expert Dr. Pisani stated that death from pulmonary embolism was not generally predictable in advance (T.2207) and is more likely to occur in a pregnancy carried to term than during a first trimester abortion (T.2208). He also testified that amniotic fluid embolism, another leading cause of death, does not occur in the first trimester and cannot be prediagnosed as it is ascertained only by autopsy. (T.2208-09.)

[81] The medical conditions which were certified under a "preserve life" standard in New York prior to 1970 were those pre-existing conditions, such as rheumatic heart disease, tumors, etc., that are classified as "indirect" causes of maternal deaths. (Pl. Exh. 10 Table 4/T.890, slip op. at 13-4.)

> follow for any particular woman who was that markedly obese [and] at the time I saw her [said], "Doctor, under no conditions do I want to continue this pregnancy." That would create a problem for me because I couldn't look down the road and know whether she might develop ancillary complications that might threaten her.[82] (T.1214.)

Medical science can identify certain groups of women who run a substantially heightened risk of death from pregnancy and labor. Women under great stress and tension are more likely to die from hypertensive states of pregnancy than those who are not.[83] (Sloan, T.1641-51.) Black women who run disproportionate risks of mortality and morbidity in pregnancy suffer more frequently from hypertension. (Pisani, T.2212.)

Teenagers and older women also face substantially higher risks of maternal death than their 20-24 year-old counterparts. Slip op. at 137, 150.

The predictability of danger increases as pregnancy progresses, but, by the time a doctor can certify with

[82] Similarly, it is impossible to predict which individual with an IUD in place would be killed by infection later in pregnancy (Hodgson, A.197); likewise with the woman suffering from anemia (Romney, T.1160), severe varicose veins (Romney, T.1119, 3935-36), or cystitis which could cause a renal abscess late in pregnancy (Romney, T.1120).

[83] The availability of legal abortion not only virtually eliminates abortion-related mortality resulting principally from the complications of illegal and self-induced abortion, *see* n. 78, *supra*, but also accounts for a decrease in mortality among women who have a high risk of encountering serious problems by permitting them safely to discontinue an unwanted pregnancy they would otherwise have carried to term. Complications arising out of or exacerbated by the stress of unwanted pregnancy are reduced.

some certainty that a woman might die, it will probably be too late to save her by any medical intervention.[84]

b. The Hyde Amendment Standard Is Alien to Good Medical Practice and Has Inhibited Doctors' Treatment of Medicaid-Eligible Women.

The trial court found that:

> The evidence requires the conclusion that the medical profession will interpret and has interpreted the Hyde-Conte Amendment and its successors narrowly rather than attempt to demonstrate to DHEW the basis of their medical judgments in cases in which they are satisfied that abortions are medically necessary for the pregnant woman's health but in which they can have no confidence that they could produce clinical data demonstrating to the satisfaction of DHEW that certainty of life endangerment or of severe and long-lasting physical health damage that the enactments appear to require. Slip op. at 159-60.

To enhance predictability by waiting to see how pregnancy progresses was inimical to plaintiffs' witnesses' principles of good and appropriate medical care. (Romney, T. 1067-77; Rothschild, T.690-91.) Yet this is what the Hyde standard requires.

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[84] The New York Study (Def-Int. Exh. H, p. 30/T.2227) reveals that emergency abortions had been performed for all 13 women who died from preeclampsia. The testimony confirmed that a woman can die of toxemia even with the best medical care. (Hofmann, T.1433.) Similarly, a late abortion does not resolve the danger created by pulmonary or amniotic fluid embolism. Nor can a late abortion or treatment counteract the rapid infection resulting from an IUD *in situ* (Hodgson, A.197).

The trial court found:

> The supporting data for safe certification cannot be at hand at the time when professional judgment would approve a termination of the pregnancy as "medically necessary," as that term is understood in the medical profession. The effect tends to be to relegate abortion to the status of a crisis intervention procedure. Slip op. at 110.

The statistics confirm that Medicaid abortions under the Hyde standard have been limited to crisis situations. Slip op. at 158-59. Behind those statistics lie the real problems of plaintiff class members for whom the denial of abortions may result not only in increased risks, but, in some cases, permanent health damage.[85] Serious complications arise from delay because it both increases the risk of the abortion itself and exacerbates the risks of the underlying condition. Slip op. at 113-14, 161.

The trial court found that the inhibiting effect of the Hyde Amendment resulted in

> . . . the very substantial risk that professional reluctance to certify under a standard alien to medical experience and terminology would deny medical assistance to women in instances in which

[85] A Texas Medicaid-eligible teenager was turned down by the state for an abortion because she had not reached the crisis point. This 15-year-old girl with chronic glomerulonephritis applied for prior approval pursuant to state law through her doctor, Dudley Powell. Two doctors agreed that this condition, a kidney disease, made her pregnancy life-threatening. Their request was denied, evidently because chronic glomerulonephritis was not considered a condition which would "endanger the mother's life if the fetus were carried to term." (Pl. Exh. 455A-D, A.300-303.)

it would not have been withheld under the older abortion committee standards. Slip op. at 99-100.

Therapeutic abortion certifications under state laws before 1973, such as the "preserve life" standard in New York, were found relevant by the trial court for two reasons. First, testimony and studies on those certifications show that they were made arbitrarily, depending on the status of the doctor and the wealth of the patient, not on an expected difference based on individual doctors' medical judgments.[86] (Tietze, T.899, 917; Romney, A.217; Pl. Exh. 10/Table 2/T.890.) Some hospitals even had abortion quotas, irrespective of need. (Tietze, T.938.)

Second, the trial court found that the Hyde standards signaled a return to a practice even narrower than these arbitrary standards. Slip op. at 159.

Medical testimony was in agreement on the inhibiting effect of the Hyde standards on doctors, standards requiring doctors to single out abortion and treat their poor pregnant patients differently than any other Medicaid or private patient. (Romney, T.1155-66; Eliot, A.164.)

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[86] Even in the same hospital, private patients were about four times as likely to get certified for medical non-psychiatric conditions than the poor. In 1964, at University Hospital, there were 14 times more certifications for rubella than at Bellevue, the public part of the hospital, yet admittedly the poor suffer more from the certifiable conditions. (Belsky, T.3523.) *See* slip op. at 13.

7. The "Medically Necessary" Standard Is Understood by the Medical Profession.

The trial court found that:

> The medical evidence made it abundantly clear that the medical profession does not treat pregnancy, the threat of complications in pregnancy, and the factor of the pregnant woman's attitude toward her pregnancy and child bearing in terms related to determining whether the "life of the mother would be endangered if the fetus were carried to term." Slip op. at 95.

The witnesses agreed, and the trial court found, that a "medically necessary" standard did allow doctors the scope to exercise their best medical judgment. Slip op. at 88-89. (Rothschild, A.148, T.709-10; Romney, A.215-16; Eliot, A.161; Belsky, T.3570.) The evidence shows that the medical necessity standard approved in *Doe v. Bolton* and *Beal v. Doe* is in fact the standard applied by the medical profession to their general practice and to pregnancy in particular. Slip op. at 88-89, 101. (Belsky, T.3570; Rothschild, T.709-10.) The *Doe v. Bolton* formulation of the medical necessity standard promotes the exercise of good medical judgment in three crucial ways: (1) it permits a comprehensive evaluation of all factors affecting health; (2) it embodies the essential principles of preventive medicine;[87] and

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[87] A witness used the example of a teenager with strep throat. Penicillin would cure it but it is also probable that it would get better without treatment. If penicillin is not given, there is a risk of rheumatic fever. This, too, could be self-correcting, or it could produce heart damage that would shorten life by 20 years. (Hofmann, A.207-08.)

(3) it allows flexibility in weighing the risks and benefits of medical intervention.[88]

8. There Are No Alternatives For Poor Women Who Need Medically Necessary Abortions.

Poor women seeking to avoid health threatening pregnancies cannot depend on contraception. Those methods most effective in preventing pregnancy present the greatest danger to health.[89] Without abortion as a back-up for contraceptive failure, poor women will be pressured into foregoing safety for effectiveness[90] or submitting to irreversible sterilization, which

[88] The trial court found that even those doctors who testified for the intervenor, who oppose abortion on principle, do not disagree "that from a therapeutic viewpoint abortion would be medically necessary to preserve the pregnant woman's health in significant classes of cases falling outside the classes delineated in the successive Hyde Amendments." Slip op. at 310.

[89] A leading study shows that people who use various methods of contraception run the following risks of unintended pregnancy during the first year: oral contraceptives, 6%; IUD, 12%; condom, 18%; diaphragm, 23%; foam, 31%; rhythmn, 33%. *See* Pl. Exh. 27/T.1567, A.266. However, the two most effective methods are also the most dangerous, with mortality from the pill being 58.4 deaths per 100,000 pill users aged 40-44 who smoke. The IUD mortality rate is about 1 per 100,000 users, a rate that is biased downward since it is estimated that most unwanted pregnancies with an IUD *in utero* were terminated by legal abortion in the first trimester. *See* Pl. Exh. 16, Table 1/T.970-71.

[90] Dr. Hodgson testified about a mother of three who had cancer with a prognosis of five years to live. She became pregnant using a diaphragm and could not use the pill since it could accelerate the cancer. (T.37.) Women who are smokers, obese, or who have high blood pressure are also warned against the pill. On the basis of all the data, Dr. Tietze concluded that in terms of risk of life the safest procedures for regulating fertility were use of the diaphragm and condom, which are "perfectly safe, although not 100% effective—and the termination of pregnancies resulting from contraception failure. . . ." (Tietze, T.971; Pl. Exh. 16, p. 3/T.970-71.)

they may not freely choose, but which is federally funded.[91] (Sloan, T.1675-76.)

Medicaid women who need medically necessary abortions have few options. A few may qualify for Medicaid abortions under the life-endangering standard, but not until it is "crisis intervention." Slip op. at 159, 110. The trial court found that the delay inherent in a doctor marshalling evidence and monitoring pregnancy until the woman's life is "endangered" would increase serious complications.[92] Slip op. at 97. (Romney, A.218.)

Women denied Medicaid abortions are left few choices. They may undergo a great sacrifice to pay for a legal abortion and suffer the increased risk of the delay in raising funds. They may jeopardize their lives by self-abortion or illegal abortion. Or they may unwillingly continue an abnormal pregnancy which, as it

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[91] The Department of HEW has recently issued new regulations to prevent situations of sterilization abuse on Medicaid women. 45 C.F.R. 205.35. Before 1973, approval by hospital abortion committees was often conditioned on the woman's agreement to have a concurrent sterilization operation. (Pl. Exh. 289, p. 93; Eliot, T.476.) *See* also Brief of *Amici Curiae* National Lawyers Guild, *et al.*

[92] This finding by the trial court was supported not only by expert testimony but by Dr. Tietze's description of the experience in Sweden, where in 1938 the law allowed abortion only where it was necessary to avert a serious threat to the woman's life or health due to disease, physical impairment or weakness. (Pl. Exh. 8, p. 55/T.885.) Swedish doctors interpreted the law as requiring that they monitor patients to see whether problems in fact developed. (T.1009.) The result was that by 1968, 57% of the abortions in Sweden were done in the second trimester, and the mortality for legal abortion was greater than the mortality for childbirth. The law was then changed. Subsequently, 90% of abortions were done in the first trimester with a dramatic morbidity and mortality reduction. (T.1010.)

progresses, increases the risks to their life and health. Each of these options increases the risks to the lives and health of women denied medically necessary abortions.

The chair of an HEW Task Force directed to find alternatives to abortion concluded:

> [Abortion] is an option, uniquely, which is exercised between conception and live birth. As such, the literal alternatives to it are suicide, motherhood, and, some would add, madness. (Pl. Exh. 248, A.299.)

The trial court concluded that "[i]ndigent women, dependent on public assistance provided through AFDC programs are dependent on Medicaid. . .for legal abortions." Slip op. at 75. Even in states where the welfare allotment is above the national average, welfare recipients "must live at a miserable and humiliating level of bare subsistence." Slip op. at 76-77. (Dweck, T.1791-93.) The cost of a safe, legal abortion is beyond the means of most poor women. In 1976, the average cost of an abortion ($280) exceeded the average *monthly* AFDC payment for a *family of four* ($238) by $42. (Pl. Exh. 24/T.1534; A.264.) The average cost of an abortion to a Medicaid woman is even greater since Medicaid women are three times more likely to rely on hospitals for their general medical care (slip op. at 76), and women seeking medically necessary abortions, particularly teenagers, are more likely to require a more costly second trimester abortion.[93] Slip op. at 76. (Romney, A.221-22.)

[93] The cost of second trimester abortions performed in hospitals ranges from $350 to $1,000 or more, thus foreclosing the possibility for such abortions for most poor women. (Kissling, T.1453.)

Even a doctor who will perform an abortion without charge is often limited by the hospital's refusal to admit a patient without prepayment or a prior guarantee of payment, as with cases of plaintiffs Ann Moe and Mary Doe. (Bingham, A.183; Hodgson, A.196.)

An indigent woman cannot depend on philanthropic or charitable institutions to assist her in obtaining an abortion. The district court specifically found that abortions are not generally available at free public hospitals or through philanthropic assistance, or at reduced clinical charges. Slip op. at 74-75. Although providers do perform some free or reduced fee services, they can do so for only a very few Medicaid recipients denied medically necessary abortions. Slip op. at 77-78. (Kissling, T.1482.)

Faced with the utter inaccessibility of legal abortion, a woman may use her family's meager stipend to obtain an abortion, or try to raise the money herself. *See* n. 35, *supra*.

Women whose lives and health are most endangered by unwanted pregnancies are least likely to be able to raise private funds or to ferret out the scarce charitable resources to fund a legal abortion. Teenagers are financially dependent on their families, whom they often cannot tell about their pregnancy, and they are not likely to have outside sources of income. Fifteen-year-old plaintiff Ann Moe, with a history of mental instability, institutionalized for most of the three years prior to her pregnancy, would hardly be capable of aggressively searching out alternatives to fund a legal abortion. A young girl already traumatized by rape or incest, or in fact a woman of any age with serious mental problems, would hardly be expected to deal

with the additional pressure of raising funds for a legal abortion.

Failing to obtain the money to finance a legal abortion, women may be forced to undergo self-abortion or non-legal abortion. Women obtaining illegal abortions today are exposed to higher risks than women who obtained them in the 1960's. (Tietze, A.198.) (*See* Section C-3, *supra*.)

Women denied medically necessary abortions are likely to be at an advanced stage of pregnancy by the time they try to self-abort or seek out a non-legal abortion, and thus face even greater risks than at earlier stages. *See* slip op. at 104-10; and Section C-3, *supra*.

Adoption is at best a desperate alternative of last resort. Even in a normal pregnancy it is a painful and often unavailable option to poor women.[94] Katherine Krauser, an AFDC mother of five, testified that despite her decision to give up her baby for adoption at birth, Ms. Krauser could not relinquish the infant when a woman arrived at her home four months later to claim "baby Krauser." (A.178.) Although she had had three unwanted pregnancies, she felt that giving up her children for adoption was an unacceptable option: it would be "like selling them on the slave market." (T.1761.)

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[94] The children of Medicaid women are not the most likely to be adopted. They are likely to be bounced "from foster home to foster home, and from institution to institution." Hofmann, T.1386. HEW reports indicate that as many as 350,000 children are in foster care, including 90,000-120,000 with special needs. (Pl. Exh. 287, p. 1.)

Dr. Judith Belsky gave testimony concerning patients who had both had an abortion and given up a baby for adoption. "They said giving up the baby for adoption was much worse. Whatever guilt . . . they had about the abortion they got over, but that they never could get over the sense of loss of the child they had given away. . . ." (A.192-93.) For women who know their child will be deformed or genetically impaired, adoption is not an option. Nor is it an option for teenagers at great physical and emotional risk in pregnancy, whose children are more likely to be born with physical and mental defects. Slip op. at 139-40. In fact, the Schuck Report indicates that 85% of teenage mothers keep their children. (Pl. Exh. 244, p. 3.)

The absence of government funding for medically necessary abortions for many women does not lead to normal childbirth but to physical and mental suffering, or possibly death. They may bear severely defective children doomed to lead short and painful lives, or to live their lives in institutions or as agonizing burdens to their parents and existing families. Surely this suffering of poor women and their children cannot be said to encourage normal childbirth.

9. Abortion is a Matter of Religious and Conscientious Belief as to Which Regligions Are Deeply and Irreconcilably Divided.

The explanation for the terrible toll on poor women's health exacted by the Hyde Amendments can be found in neither medical, fiscal nor demographic considerations; rather the Hyde Amendments reflect the fundamental religious division in our society over the morality of abortion and the proper role of civil law in the

face of religious dispute on a matter of private conscientious decision.

At the heart of the abortion controversy is a confrontation over religious faith and moral conviction on a matter of ultimate concern. As the district court found, "the issue is one involving moral principle and resting on religious teaching." Slip op. at 238. The differing beliefs, grounded in Scripture and moral reasoning, are "identifiably religious and constitute an integral element of denominational religious difference." Slip op. at 238.

The differences turn not on science or medical fact, but on "considerations of divine purpose . . ., the divine relation to the creation of life," (slip op. at 239) and of the role of the individual in shaping the divine plan and determining the fundamental question of human existence and human fulfillment.

Those who adhere to the anti-abortion view share the Creationist perspective, viewing the fetus as created by God at the "moment" of conception and confering ultimate value on the fertilized egg. By contrast, the pro-choice view holds that, though life is a gift of God, the decision whether to bring a life into the world is confided to the conscience of the pregnant woman. She decides according to her interpretation of God's purposes and her ultimate moral and ethical precepts. Whether described as religious or moral, "all the views are rooted firmly in religion, in belief in God's will, in God as the author of life, and in God's concern with humankind." Slip op. at 239.

The two views lead to diametrically opposed approaches to the role of law. The Creationists oppose legal abortion because it transgresses natural law,

divine in origin. They would have civil law impose this view on all women. The pro-choice view rejects as intolerable a rule of law that conflicts with or intrudes upon "the rule of conduct that moral theology explicates." Slip op. at 240. They insist that civil law leave to women the decision to choose or never to consider abortion, in accordance with their individual consciences and religious beliefs.

The differences among the denominations demonstrate: (1) that the abortion question is one upon which religions are irreconcilably divided; and (2) that the decision or non-decision in respect to abortion is one which, by its nature, inheres in the realm of the free exercise of religion and conscience.

a. Theological Positions Opposed to Abortion

i. The Roman Catholic Doctrine

The largest, most powerful and active denomination condemning abortion is the Roman Catholic Church. Abortion is a grave sin punished by automatic excommunication. (Smith, T.2117-2118.) The Declaration on Abortion issued in 1974 by the Sacred Congregation for the Doctrine of the Faith, is the Church's most definitive and authoritative statement on the morality of abortion. Slip op. at 169. (Def.-Int. Exh. E/T.2100-2102.)

Citing Scripture, Church teachings and moral reason, the Declaration grounds the impermissibility of abortion on the belief that human life begins with fertilization. (*Id.* pp. 2-3.)[95] The humanity and inviola-

[95] The term "human life" is used here, as it is in doctrine, as indicating equivalence to a born human being. Intervenors' witness Father William B. Smith testified that the fetus is "human life

bility of the fertilized egg is based neither on science nor on a certainty that the soul is infused at the first moment, but on theological doubt as to animation. It is a matter of " 'moral affirmation' . . . independent of the philosophical problem" of ensoulment. Slip op. at 171.

The scientific discovery that the genetic code is established at fertilization merely confirms the Church's teaching:

> [I]t is not up to biological sciences to make a definitive judgment on questions which are properly philosophical and moral, such as the moment when a human person is constituted or the legitimacy of abortion. From a moral point of view this is certain: even if a doubt existed concerning whether the fruit of conception is already a human person, it is objectively a grave sin to dare to risk murder. "The one who will be a man is already one." (Def.-Int. Exh. E, p. 6/T.2100-2102.)

As the district court explained: "[r]ational analysis and biological learning may, in the teaching of the Declaration, suffice to impose the same obligation to respect human life, but the obligation is seen nonetheless as religiously imposed." Slip op. at 228.

"Roman Catholic doctrine puts on the embryo and fetus a value equivalent to that placed on the life of born human beings, ignoring its futurity as irrelevant to a value analysis determined by considerations of divine purpose and of the divine relation to the crea-

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with potential, but if potential as against actual, it is an actual human life. If it is potential, it is not actual." (Smith, T.2128.)

tion of life." Slip op. at 239. The Declaration recognizes no justification for abortion—not even the life of the pregnant women. Slip op. at 169. (Def.-Int. Exh. E, p.6/T.2100.)

Catholic teaching distinguishes "indirect" abortion, i.e., "operations, treatments and medications which do not directly intend termination of pregnancy, but which have as their purpose the cure of a proportionately serious pathological condition of the mother . . . when they cannot be safely postponed until the fetus is viable . . . ." Slip op. at 171-72. The double effect principle does not justify abortion to save the woman's life but does encompass a number of life-threatening circumstances (*see* slip op. at 172-73), as well as removal of an ectopic pregnancy. Doctrine also permits immediate treatment of rape and incest victims so long as the treatment occurs to prevent conception. Slip op. at 173.

Roman Catholic doctors and nurses may not participate in abortions and to be compelled to do so would be a violation of conscience. Slip op. at 174. (Smith, T.2129-30.) Father Smith testified that a Medicaid program which reversed the terms of the Hyde Amendments, excluding childbirth services while funding abortion, would impede a poor Catholic woman's free exercise of religion. (Smith, T.2131-36, A.231-33.)[96]

[96] The Pastoral Letter "Human Life in Our Day", issued by the National Conference of Catholic Bishops in 1968, likewise insisted, with respect to family planning programs, that society should "never dictate, directly or indirectly, recourse to the prevention of life or to its destruction in any of its phases." Hearings Before the Subcommittee on Constitutional Amendments of the Senate Committee on the Judiciary, 93rd Cong., 2nd Sess., on S.J. Res. 119 and S.J. Res. 130, Vol. I (Abortion—Part 1) (1974) (hereinafter Abortion Hearings I), p. 318.

However, Father Smith also testified that Catholics must pay taxes, even if a portion is used for what the Church considers immoral purposes. (Smith, T.2113-14.)

ii. The Mormon Church

The Church of Jesus Christ of Latter Day Saints, the Mormon Church, views abortion as "a revolting and sinful practice," subject to disciplinary action by "church councils as the circumstances warrant." Abortion is permitted in "rare" circumstances where medical counsel confirms that "life or good health of the mother is seriously endangered or where the pregnancy was caused by rape and produces serious emotional trauma in the mother." Counseling with presiding priesthood authority for the purpose of receiving "divine confirmation through prayer" is required prior to the abortion. (Abortion Hearings I, p. 318.)

iii. The Position of the Lutheran Church—Missouri Synod

As the only Lutheran sect to oppose abortion, the Synod expounds the view, derived from Scripture, that "life comes into being by an act that shares in the creation power of God," and that nascent life—established at the blastocyst stage—derives value because it stands in eternal relationship to God. (Abortion Hearings I, p. 321.) Slip op. at 177. The woman's life takes precedence, however, over nascent life. Though broader than the Roman Catholic, this exception is regarded as "indirect abortion" because it is "a consequence of an action undertaken to preserve life." Slip op. at 177. (Abortion Hearings I, p. 321.)

iv. Orthodox Jewish Teaching

The Orthodox Jewish position views abortion as akin to homicide, but as justifiable killing in self-defense where the pregnant woman's life is threatened. Slip op. at 175. This warrant for abortion, grounded in the Talmud, embraces both physical and psychological (suicidal) threats to life, (Feldman, T.1863-4), and includes certain cases of rape. Slip op. at 176. In life-threatening circumstances abortion is mandatory until the head of the fetus emerges. Many Orthodox Jewish theologians feel, however, that at some point early in gestation ". . . the fetus is to all intents and purposes a human being insofar as questions concerning destruction of the fetus are concerned." (Abortion Hearings I, p. 316, Rabbi David Bleich.) Slip op. at 176.

b. Theological Positions Viewing the Abortion Right as a Matter of Religious Liberty

In the past two decades, many religious bodies have officially affirmed their view that the right to terminate a pregnancy is a necessary and sacred aspect of religious decisionmaking and religious practice.[97] There are three major theological approaches among the prochoice denominations.

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[97] Among the denominational groups which have taken stands recognizing abortion as a matter of conscientious decision and religious liberty are all the eight major Baptist denominations, see § iii at n.101, *infra*, the Division of Homeland Ministries of the Christian Church (Disciples of Christ), the Board of Homeland Ministries of the United Church of Christ, the United Methodist Church, the American Ethical Union, the United Presbyterian Church in the U.S.A., the Lutheran Church in America, the American Humanist Association, the Moravian Church in America, the Church of the Brethren, the Unitarian Universalists, the Reorganized Church of the Latter Day Saints, the Reformed Church in America, the American Jewish Congress, Catholics for a Free

i. Conservative and Reform Jewish Teaching

As explained by plaintiffs-appellees' witness, Rabbi David M. Feldman, Conservative and Reform Judaism follow the more liberal tradition in Jewish law and permit abortion where the woman's physical or mental health is threatened and may even mandate it in life-threatening situations.[98] The line between mandatory and permitted abortions is not a sharp one, however. Where abortion is permitted, it is, as "an outgrowth of the whole Jewish tradition . . . recommended," even if not strictly mandated. (Feldman, T.1930-31, 1935-36.) The governing principle is that the woman's "welfare is primary and her statement of her welfare is primary." (Feldman, T.1875-76.) Slip op. at 181. Where abortion is necessary to preserve life or health, it is a religious duty equally or even more important to the practice of the faith than the observance of ritual. Slip op. at 181. (Feldman, T.1877-80, 1916-17.)

The liberal Jewish tradition recognizes a broad range of circumstances where abortion is warranted, including the pregnancy of a very young teenager, or a pregnancy which threatens the nurture of existing

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Choice, Union of American Hebrew Congregations, United Synagogue of America, Young Women's Christian Association, Commission of Social Action of Reform Judaism, Church Women United, Women of the Episcopal Church, and the Friends Committee on National Legislation, Pl. Exh. 320/R. 233, Cong. Rec. daily ed. S.14564-65, August 26, 1979. In this case, the Women's Division of the Board of Global Ministries of the United Methodist Church intervened as plaintiffs "on behalf of itself and the membership of United Methodist women." (Hoover Aff., ¶ 1,A.129.)

[98] This view is embodied in the resolution of the Biennial Convention of the United Synagogue of America which reflects as well the views of the Law Committee of the Rabbinical Assembly. Slip op. at 182. (Pl. Exh. 320/R. 233.)

children, or extreme pain in childbirth. Where the woman is suffering mental anguish over the possibility of bearing a defective child, she may abort even though that possibility alone would not warrant abortion. Abortion is also permitted to prevent anguish over bearing a child out-of-wedlock. Slip op. at 179-80. (Feldman, T.1865-74.)

The primacy accorded the woman's health and welfare flows from two basic teachings: the Biblical injunction to "choose life" (T.1907), which, in most cases, places preservation of one's health above even the commands of the Torah, slip op. at 178-79 (T.1859); and the principle that the fetus is only potential life until birth. Slip op. at 181. (Feldman, T.1858.) Rabbi Feldman described this principle as "immutable" (T.1922) because "the point when biological life passes from potential human life to human life has got to be a metaphysical, religious, philosophic determination rather than a medical, biological or even a legal one." (Feldman, A.223.) Because the Hyde Amendment creates a serious obstacle to a poor Jewish woman's access to abortion, it interferes with her ability freely to exercise her religious choice. (Feldman, T.1935-36.)

ii. The Mainstream Protestant Perspective

Dean Philip J. Wogaman, a United Methodist minister and recent past president of the Society of Christian Ethicists, explained that it is generally accepted among mainstream Protestant denominations and ethicists and others that "nearly no aspect of life is more sacred, closer to being human in relation to God than bringing new life into the world to share in the gift of God's grace and God's covenant." Slip op. at 192-93. (Wogaman, T.1959.) There is a duty, founded in the Bi-

ble as interpreted through the person of Jesus Christ, to make a deliberate decision about child-bearing according to the principles of responsible parenthood. One must consider whether one "is bringing a life into the world under conditions which make it possible for that life to participate in God's intention . . . [and under conditions which will not] threaten to undermine the theologically understood fulfillment of already existing human beings." Slip op. at 193-94.

Though there are no categorical rules (Wogaman, T.1966), there are many circumstances in which it might be contrary to God's purposes to bear a child: where there is risk to the life or physical or mental health of the woman or capacity of the future child; where, as in the case of some teenagers, the new life might not receive the nurture necessary for human fulfillment; where the pregnancy is close to menopause and would adversely affect the woman or her existing family and the social situation of the child; where the pregnancy results from rape or incest; or where the socio-economic condition of the family makes it impossible to nurture the new life emotionally and spiritually as well as physically.[99]

Abortion may be "mandatory as a person's responsibility before God" (Wogaman, T.2033), and that judgment is "referred to the woman and her own religious conscience." Slip op. at 197. The decision of responsible parenthood involves a religious duty of the highest order, transcending that of ritualistic practice. (Wogaman, A.223-24.)

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[99] Slip op. at 194-95; *see also* Pl. Exh. 320/R.233; Statements of United Presbyterian Church, U.S.A.: Women's Division, Board of Global Ministries, United Methodist Church; Lutheran Church in America; and the Presbyterian Church in the United States.

Concern for the fetus is always subordinated to concern for existing human life. It is generally accepted that "human personhood in the sense in which the person receives its maximum value in relation to the Christian faith—does not exist in the earlier phases of pregnancy . . . .[T]he degree of sanctity or value ascribed to fetal life increases correspondingly to the stages of fetal development." Slip op. at 195-96. (Wogaman, T.1984.) Some Protestant theologians accept the Jewish view that personhood is not attained until birth. (Wogaman, T.2072.)

The operative consideration is not biological, however. Virtually all theologians and ethicists share the view that biology does not confer value but that "the value of the entity arises from its relation to ultimate reality" and that this "value question is one of moral judgment and ultimately religious in origin." Slip op. at 198.[100]

Dean Wogaman described the Hyde Amendment as denying or impeding the exercise of the duty of responsible parenthood. The Amendments invade the realm of free exercise because "[t]he concern here is the whole fabric or conditions of human existence" not limited simply to the case of risk to the health of the mother. (Wogaman, T.1972-73.)

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[100] Dean Wogaman's own view illustrates the relationship between science and moral judgment. For him, personhood, which does not preclude abortion but enhances its gravity, does not begin until the fetus is capable of awareness, since "the covenant relationship, . . . which defines the very essence and heart of our faith, . . . is something which occurs between God as the Creator of reality and those who have begun to experience the reality which God has created." (Wogaman, T.1985.)

Because personhood is ultimately a moral rather than a biological determination, technological viability does not determine value

iii. The Baptist Perspective

Dr. James E. Wood, Executive Director of the Baptist Joint Committee on Public Affairs,[101] testified that there is no distinct Baptist discipline or norm applicable to abortion. Slip op. at 183-84. Decisions about procreation are matters of conscience because bringing a life into the world is "a moral decision [which] comes out of some sense of moral awareness [and] . . . takes on real religious meaning because it is being absolutized as an ultimate, a supreme obligation." (Wood, T.3184; A.238.) Slip op. at 184-85. Voluntarism in matters of faith or ultimate concern, i.e., liberty of conscience, is itself "the most precious single principle for the Baptist understanding of religious faith and in particular Christian faith." (Wood, T.3181-83.) Slip op. at 184.

Baptists believe that the right of individual conscientious decision on the question of abortion is universal. It is a religious matter for everyone because it involves a sense of the sacred, of ultimate concern, and moral imperatives which are, or function for the individual as, divine commands. (Wood, T.3181-85, 3212-

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although today it corresponds roughly to the dawning of awareness. Thus, technological developments advancing the point of viability would not alter the duty to make a decision of responsible parenthood. (Wogaman, A.226-27.)

[101] The Baptist Joint Committee is composed of eight bodies: the American Baptist Churches in the U.S.A.; the Baptist General Conference; the National Baptist Convention, Inc.; the National Baptist Convention of America; the North American Baptist Conference; the Progressive National Baptist Convention; the Southern Baptist Convention; and the Seventh Day Baptist General Conference. These groups have a combined membership of 30 million people. (Wood, T.3177-78.)

20, 3244-45.) Conscience dictates what value is ascribed to fetal life[102] as well as what considerations justify abortion, whether as an affirmative or reluctant moral necessity.[103]

The Baptist bodies generally view abortion as acceptable in varying degrees in situations where pregnancy is involuntary, due to not only rape and incest but extreme youth and contraceptive failure; is threatening to the mental, emotional and physical health of the woman; or unwanted for a wide range of reasons, including significant familial considerations. Slip op. at 191.[104]

Notwithstanding that various Baptist bodies hold differing views about fetal life and acceptable indications for abortion,[105] they agree that public policy must allow persons to make the abortion decision for them-

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[102] Dr. Wood emphasized his agreement with the principle that the attribution to the fetus of the value of human life is not a biological judgment, but rather a moral judgment. (Wood, T.3210, 3241, 3308-10.)

[103] In response to the U.S. Attorney's suggestion that some women would not take the decision seriously enough to qualify it as religious, Dr. Wood stated that "Government does not have the kind of competency to determine the depth or degree of soul searching, the extent of anguish and pain that persons experience to arrive at that point of decision-making." (Wood, A.245.)

[104] Wood, T.3237-38; Pl. Exhs. 131, 132/T.3173-74.

[105] *See* slip op. at 185-90. (Pl. Exh. 132/T.3173.) For example, the Baptist General Convention of Texas, the largest component of the Southern Baptist Convention, urged "[r]ecogni[tion] that Christian Love at times dictates an affirmative action against an attitude of 'doing nothing'" (Pl. Exh. 132/T.3173), whereas the Southern Baptist Convention has reaffirmed the Biblical sacredness and dignity of all human life "including fetal life." Slip op. at 189. Dr. Wood testified that it is absolutely incomprehensible to him to think of the fetus as human life or a person until birth. (Wood, T.3241-43.)