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Conditional Spending and Compulsory Maternity

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Conditional Spending and Compulsory Maternity¹

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I. Introduction

Lack of health insurance is widely understood to create a barrier to healthcare services in the United States.³ At a time when more than 45 million Americans are uninsured,⁴ and many

¹ Reva B. Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 308, n. 188 (1992) (describing the term compulsory maternity in historical context). Feminists in the mid 1800s railed against marriage as a form of legalized prostitution wherein women were subjected to the sexual whims of their husbands and were forced, by the ever strengthening physician movement to end access to midwives and to abortion, to bear children as a matter of “duty” in marriage. *See id.* The larger ideal of autonomy for women involved freeing women from the physical demands of marriage and childbearing as well as an overlapping desire for mental freedom through such rights as suffrage. *See id.*

² Willburt D. Ham Associate Professor of Law, University of Kentucky College of Law. Many thanks to the participants in the International Conference on Feminist Constitutionalism, the participants in the Washington University School of Law Works-in-Progress Workshop, and the University of Cincinnati Faculty Forum. Thanks to Todd Allen and Anna Girard for diligent research assistance. Thanks always DT.

³ *See* Kaiser Commission on Medicaid and the Uninsured, *The Uninsured A Primer: Key Facts About Americans without Health Insurance*, 7-8 (2008), <http://www.kff.org/uninsured/upload/7451-04.pdf> (reporting that the uninsured are more likely to forego or postpone medical care than the insured; one statistical example given is that about 25% of uninsured adults had to forgo care in 2007 because of cost, compared to 3% of those covered by private health insurance); Sara R. Collins, Jennifer L. Kriss, Michelle M. Doty, and Sheila D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families*, The Commonwealth Fund, 14 (2008), http://www.commonwealthfund.org/usr_doc/SurveyPg_Collins_losing_ground_biennial_survey_200.pdf (describing how loss of insurance creates barriers to medical care); *Women’s Health Insurance Coverage Fact*

more are seeking government assistance accessing healthcare due to job losses and employment benefit cutbacks,⁵ the conditions placed on government spending for healthcare are a particularly current issue. The expansion of the State Children’s Health Insurance Program (SCHIP) in the first weeks of the Obama administration signaled that the federal government may be willing to respond to this nation-wide need, but federal funding often demands a sacrifice of the recipient, known as conditions on spending.⁶ Congress has long been understood to have not only the power to spend “for the general welfare” but also to have the authority to attach conditions to the funds that the recipient (whether state or individual) must accept to receive the funds.⁷ The nation’s major public healthcare programs, such as Medicare, Medicaid, and SCHIP, are all conditional spending programs. Given the desire to expand and revise such programs, it is important to consider the impact that conditions placed on federal healthcare spending may have on the individuals who rely on that spending.

The predicament is that the Supreme Court’s Spending Clause jurisprudence often evaluates conditions on spending in such a way that it fails to recognize the individuals affected by conditional spending. The Court’s major decision regarding conditional spending, *South Dakota v. Dole*, focused on the federal-state relationship in setting forth a test for understanding the constitutional boundaries limiting Congress’ ability to place conditions on federal funds.⁸ That benchmark facilitated a disconnect, however, that analytically separates the individual from the conditional spending program, a divide that has allowed Congress to impinge on individual rights when it could not otherwise do so.

Examining the Court’s decisions allowing state and federal governments to burden the privacy right to obtain abortion by withholding funds in public healthcare programs, particularly Medicaid, provides a striking example of this disconnect. This area of the law is deserving of mining for a number of reasons. First, the legislative intent of the restrictions on federal spending for reproductive services is unusually clear, as the chief sponsor and author of the legislation, known as the Hyde Amendment, openly desired to impede all women’s access to abortion.⁹ Knowing that Congress could not place direct obstacles in the path of all women seeking to terminate pregnancy, Representative Hyde chose to burden those women who rely on Congress for healthcare services by virtue of the federal funding mechanism of Medicaid.¹⁰

Sheet, Kaiser Family Foundation, 2 (2008), http://www.kff.org/womenshealth/upload/6000_07.pdf (stating “Uninsured women are more likely to lack adequate access to care, get a lower standard of care when they are in the health system, and have poorer health outcomes. . . . Women who are younger and low-income are particularly at risk for being uninsured, as are women of color, especially Latinas.”).

⁴ According to the United States Census Bureau, the number of uninsured was 45.7 million in 2007. *See Household Income Rises, Poverty Rate Unchanged, Number of Uninsured Down*, United States Census Bureau (2008), http://www.census.gov/Press-Release/www/releases/archives/income_wealth/012528.html (last visited Feb. 9, 2009).

⁵ *See* Kevin Sack and Katie Zezima, *Growing Need for Medicaid Strains States*, N.Y. TIMES (Jan. 21, 2009), available at <http://www.nytimes.com/2009/01/22/us/22medicaid.html>.

⁶ *See* Robert Pear, *Obama Signs Children’s Health Insurance Bill*, N.Y. TIMES (Feb. 4, 2009), available at <http://www.nytimes.com/2009/02/05/us/politics/05health.html?scp=2&sq=SCHIP&st=cse>.

⁷ *South Dakota v. Dole*, 483 U.S. 203 (1987).

⁸ *See id.*

⁹ Representative Hyde stated during the floor debate of the so-called Hyde Amendment: “I would certainly like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available is the HEW medicaid [sic] bill.” CONG. REC., House, 19698, 19700 (June 17, 1977).

¹⁰ *See* Pub. L. No. 94-439, §209, 90 Stat. 1418, 1434 (1976). The original “Hyde Amendment” has been modified through the years; sometimes it has allowed federal matching funds when terminating pregnancy is

Second, the Hyde Amendment and its progeny serve as a microcosm for studying the ways in which conditional federal spending impacts the individual, particularly those who are most vulnerable. Studies show that funding remains one of the greatest obstacles to healthcare access generally¹¹ and abortion access specifically for poor women, who either seek unsafe abortions or are forced to bear the child.¹²

Third, the Hyde Amendment helped to lay the foundation for the jurisprudence allowing such use of conditional spending, found in the 1977 decision *Maier v. Roe*¹³ and the 1980 decision *Harris v. McRae*.¹⁴ These two key precedents held that while neither state nor federal government may place obstacles in the path of a woman's exercise of her right to terminate pregnancy, the government need not remove obstacles “not of its own creation.”¹⁵ The Court deemed indigency to be a woman’s individual problem, and refusal to pay for abortion to encourage a policy of childbirth was adjudged constitutionally permissible. Given the Court’s imprimatur, the Hyde Amendment acted as an incentive for states to refuse to pay for termination of pregnancy, even when a woman’s health is jeopardized, because the federal government does not match the funds spent on poor women for such medical care.

Fourth, the Hyde Amendment and the jurisprudence upholding its constitutionality spawned many similar federal funding limitations; currently, at least eight federal laws prohibit spending on abortion and related services.¹⁶ These statutes can be divided into two categories, what this article will denominate “pure funding statutes” and “conscience clause funding statutes.” The sheer number of pure funding and conscience clause funding statutes highlights the breach created and maintained in the law between the condition on spending and the individual generally and protecting women’s reproductive access specifically. Further, recently published Department of Health and Human Services (DHHS) regulations allowing healthcare providers to thwart women’s efforts to obtain certain health services jeopardize not only access to abortion, but also to contraception, which stretches the *Maier* and *McRae* precedents to their limits.¹⁷

The national import of conditional spending programs such as Medicaid cannot be understated,¹⁸ but the use of their power to blockade the exercise of constitutionally protected

necessary for the life of the mother, sometimes it also includes funds for cases involving rape or incest (this is true of the current version).

¹¹ For example, according to recently published data, 40% of uninsured women did not have a Pap test, compared to 20% of insured women; 51% of uninsured women did not have a regular doctor, whereas only 12% of insured women had no regular doctor; and 67% of uninsured women needed care but did not get it due to cost, compared to 19% of insured women. Kaiser Family Foundation, Pub. No. 6000-07, *Women’s Health Insurance Coverage* (2008), http://www.kff.org/womenshealth/upload/6000_07.pdf.

¹² See CONG. REC., House, 19698, 19700 (June 17, 1977) (Representative Hyde noted that studies he had read indicated women on welfare would bear the children not seek unsafe abortions). See also Marlene Gerber Fried, *The Hyde Amendment: Thirty Years of Violating Women’s Rights*, http://www.overbrook.org/newsletter/06_11/pdfs/hrs/Civil_Liberties_And_Public_Policy_Program.pdf (last visited Mar. 8, 2009).

¹³ 432 U.S. 464 (1977).

¹⁴ 448 U.S. 297 (1980).

¹⁵ See *id.* at 316-17.

¹⁶ See section III, *infra*.

¹⁷ 73 Fed. Reg. 78072 (Dec. 19, 2008).

¹⁸ See Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL’Y 5 (2006). Professor Rosenbaum wrote:

Without Medicaid revenues, the nation would witness the collapse of an already burdened system of publicly-supported clinics and public hospitals and health systems that serve the poor, including a

rights demands consideration of the third party in the spending relationship, the individual affected by the conditions accepted by the state. The role of the third party is played not only by women, but also the physicians and other healthcare providers who are most affected by conditions on spending. Together, they highlight the gap that exists between conditional spending jurisprudence and the impact conditional spending has on individuals participating in federal healthcare programs.

This article will explore the disconnect between Spending Clause jurisprudence and women’s reproductive rights, ultimately suggesting that the *Dole* test’s focus on the federal/state relationship is too narrow. Programs such as Medicaid concern not only the inter-governmental relationship but also the beneficiary of the federal scheme, who is more than simply a third party to an agreement between the federal and state government. The individual should be better represented in the analysis; programs entrenched in the idea of cooperative federalism are not fulfilling their purpose if they fail to serve the individuals who benefit from such initiatives. The first part of this article will review the caselaw, seeking to place the precedents in context from both a statutory and theoretical perspective. Reviewing the caselaw illuminates that the Court’s analysis of these laws as Spending Clause legislation is deficient. The second part of this article will study the numerous pure funding and conscience clause funding statutes that extend the reach of *Maher* and *McRae* beyond their initial scope. Understanding the use of the spending power to create the numerous statutes described in this part helps to highlight the use of conditional spending to coerce the individuals who rely on federal healthcare programs both for benefits and for recompense. The third part of this article will explore the contours of conditional spending jurisprudence in an effort to determine where individual protection may fit within the existing framework more readily than it does now. The article concludes that the *Dole* test could protect the interests of individuals when applied in full, which is not the Court’s current practice. The article further concludes that Congress should cease inserting such funding limitations in its healthcare legislation not only because it may be unconstitutional, but also because it greatly hinders women’s access to fundamental medical services.

II. Conditions in the Caselaw

This section will explore the caselaw that facilitated the growth of pure funding statutes and conscience clause statutes. Though the caselaw combines two lines of decisions, privacy rights to obtain abortion and federal spending, the spending analysis largely has been ignored. Before tracing the Court’s precedents chronologically, this section will provide some background to place the jurisprudence in context.

A. Statutory and Theoretical Context

The caselaw is better understood with three background components in mind: the structure and intent of the Medicaid program, the “greater includes the lesser” theory, and the debate over positive and negative rights. Congress enacted the Medicaid Act as companion

substantial number of program beneficiaries. In sum, Medicaid’s role in financing health care for low-income and seriously and chronically ill and disabled populations makes it an essential part of the U.S. health care landscape.

Id. at 6.

legislation to Medicare in 1965.¹⁹ Medicaid was structured to provide medically necessary care to what were dubbed the “deserving poor,” people who fit within certain categories such as pregnant women, dependent children, the elderly, blind, and disabled, and who also met the government’s definition of poverty.²⁰ Each state submits a plan (the “State plan”) to the federal government describing how the state intends to comply with the mandatory elements of the Medicaid Act and in which permissive elements the state would like to participate.²¹ Thus, even though each state has its own plan, the Medicaid Act deliberately requires all states to ensure that all Medicaid enrollees, state-wide, have access to certain mandatory medical services, which include inpatient and outpatient hospital care, physician services (regardless of the place of service), long term care, and laboratory and radiology services.²² In so mandating, Congress departed from the predecessor legislation, known as Kerr-Mills, which had provided healthcare funding to the states with little guidance.²³ In other words, for all who qualified, Medicaid was designed to provide consistent access for five simple but far-reaching categories of medical care (and allowed states to choose from many more optional categories, such as prescription drugs, which all states cover). Medicaid has become a classic federal conditional spending program.

The Medicaid program is often described as an “entitlement” program, by which different commentators mean to implicate different theories of public spending and its enforceability by recipients. One such theory is the positive/negative rights theory of constitutionally protected individual rights. Usually the theory is expressed as the idea that the government must refrain from impinging certain rights protected by the constitution (negative rights) but it need not facilitate the exercise of those rights (positive rights).²⁴ Those who want to limit the legal entitlement also tend to want to describe constitutional rights as negative in nature. The negative/positive dichotomy is a convenient way to describe the way that the Constitution was drafted, but it is an anachronism considering the amount of money the federal government spends “for the general welfare” and with conditions attached that are designed to influence behavior. As Professor Kreimer noted twenty-five years ago, the active/inactive distinction that accompanied a bounded concept of state power seems “coarse” in the modern era, when the reach of government “has extended far into areas previously reserved to the family, market and church, and this extension confounds easy definition of positive and negative rights.”²⁵ In the context of the power to spend, wholesale acceptance of the positive/negative rights distinction seems particularly dangerous, as the government deliberately uses this power to influence behavior. Its distinction from criminal sanctions is arguably a matter of degree not kind.²⁶

¹⁹ See ROBERT STEVENS & ROSEMARY STEVENS, *WELFARE MEDICINE IN AMERICA*, 51-53 (1974).

²⁰ See *id.* at 57.

²¹ The State plan, in addition to the state’s per capita income, determines the amount of the federal match for that state’s Medicaid program.

²² See STEVENS & STEVENS at 65-66.

²³ See *id.* at 51, 66-67.

²⁴ See Susan Frelich Appleton, *Beyond the Limits of Reproductive Choice: The Contributions of the Abortion-Funding Cases to Fundamental-Rights Analysis and to the Welfare-Rights Thesis*, 81 COLUM. L. REV. 721, 734-38 (1981) (describing the negative/positive rights theory and applying it to the abortion-funding cases).

²⁵ Seth F. Kreimer, *Allocational Sanctions: The Problem of Negative Rights in a Positive State*, 132 U. PA. L. REV. 1293 (1984).

²⁶ See *id.* at 1295 (“The greatest force of a modern government lies in its power to regulate access to scarce resources.”)

The positive/negative rights theory overlays another substrate, the “greater includes the lesser” theory of government spending.²⁷ The Supreme Court has intermittently adopted the idea that Congress is not required to spend on certain programs and therefore Congress can attach conditions as it chooses to any program when it does decide to provide federal funding for a particular purpose.²⁸ The greater includes the lesser theory has been used to justify allowing governmental infringements of constitutional rights by virtue of conditions on spending; in other words, the theory supports the idea that indirectly infringing rights is permissible so long as the vehicle for infringing rights is the placement of conditions on spending, which proponents argue can always be accepted or rejected by the beneficiary of the spending. Thus, the infringement becomes a choice to waive a right rather than a governmental burden on that right. This theory dominated Justice Rehnquist’s interpretation of the power to spend, and, as will be discussed below, it has been particularly prevalent in cases involving pure funding statutes.²⁹

B. *The Federal Funding Decisions*

In 1973, the Supreme Court held in *Roe v. Wade* that the right to privacy that had been at the root of the decisions protecting use of contraceptives in *Griswold v. Connecticut* and *Eisenstadt v. Baird* extended to the decision whether or not to terminate a pregnancy.³⁰ An enormous amount of litigation has followed *Roe*, but one strain of it can be singled out easily – those cases related to government funding decisions. This line of cases can be traced to *Singleton v. Wulff*,³¹ which often is cited for recognizing and exploring exceptions to the third-party standing prohibition. But Justice Blackmun’s 1976 opinion also discussed the import of funding to both the physician and the patient involved in a decision to terminate pregnancy.³² In evaluating Missouri’s prohibition on use of Medicaid funds for so-called non-therapeutic abortions, the Court noted that a “woman cannot safely secure an abortion without the aid of a physician, and an impecunious woman cannot easily secure an abortion without the physician’s

²⁷ See Cass R. Sunstein, *Why the Unconstitutional Conditions Doctrine Is an Anachronism (With Particular Reference to Religion, Speech, and Abortion)*, 70 B.U. L. REV. 593, 597-98 (1990) (describing the “Holmesian” view of federal spending that the “supposedly greater power not to create the program includes the supposedly lesser power to impose the condition.”); Kreimer, *supra* note 24, at 1304-14 (describing and deconstructing the theory).

²⁸ The theory is most often attributed to Justice Holmes, who repeated articulated the greater includes the lesser theory in a variety of contexts (not just government spending). See, e.g., *Western Union Tel. Co. v. Kansas*, 216 U.S. 1, 53 (1910) (Holmes, J., dissenting); *Hammer v. Dagenhart*, 247 U.S. 251 (1918) (Holmes, J., dissenting).

²⁹ See *Rust v. Sullivan*, 500 U.S. 173, 193 (1991) (applying the theory by upholding selective Title X spending for family planning services). See also Lynn A. Baker & Mitchell N. Berman, *Getting off the Dole: Why the Court Should Abandon Its Spending Doctrine, and How a Too-Clever Congress Could Provoke It to Do So*, 78 IND. L.J. 459, 460, 485-86 (2003) (describing the Rehnquist approach to Spending Clause jurisprudence as the “‘greater includes the lesser’ argument” and noting that the Rehnquist Court was unlikely to abandon this approach); Lynn A. Baker, *The Prices of Rights: Toward a Positive Theory of Unconstitutional Conditions*, 75 CORNELL L. REV. 1185, 1190-91, n.12 (1990) (describing the court’s long-standing yet occasional use of the doctrine to indicate that “the State’s ‘greater’ power not to bestow the benefit or privilege at all incorporates a ‘lesser’ power to provide it conditionally” and providing a history of the theory); Kreimer, *supra* note 24, at 1308-09 (describing Justice Rehnquist’s reliance on the doctrine).

³⁰ *Roe v. Wade*, 410 U.S. 113 (1973).

³¹ *Singleton v. Wulff*, 428 U.S. 106 (1976).

³² The Missouri statute at issue prohibited use of Medicaid funds to pay for any abortion that was not “medically necessary.” Physicians who participated in Medicaid challenged the nonpayment policy for both themselves and their patients. See *id.* at 108-11. Thus, Justice Blackmun’s statements were made within the context of the close physician-patient relationship that facilitated standing for the plaintiff-physicians.

being paid by the State. The woman's exercise of her right to an abortion, whatever its dimension, is therefore necessarily at stake here.”³³ Justice Blackmun further observed that lack of funding could pose an obstacle in accessing abortion, noting that “unless the impecunious woman can establish Medicaid eligibility she must forgo abortion.”³⁴ Though these statements were support for the standing principles enunciated by the Court, they showed recognition that funding is indeed an obstacle for poor women making reproductive decisions.³⁵

A scant four years after *Roe v. Wade* was decided, the Court heard the companion cases *Beal v. Doe* and *Maher v. Roe*.³⁶ *Beal* held that the Medicaid Act did not require states to pay for non-therapeutic abortions, a decision based on statutory interpretation.³⁷ *Maher* involved a Connecticut law that limited state Medicaid benefits to medically necessary first trimester abortions. Justice Powell’s majority held that states do not violate the Equal Protection Clause if they choose not to fund non-therapeutic abortions in their Medicaid programs, the implication of which was that a state that pays for childbirth need not also pay for abortion in its Medicaid program.³⁸ Both statutory analysis and constitutional law grounded this holding, but the key aspect of the majority opinion was that the equal protection clause was not violated because poverty is not a suspect classification³⁹ and the law otherwise passed rational basis review.⁴⁰ The Court stated that even though medical costs associated with carrying a pregnancy to term are

³³ *Id.* at 117.

³⁴ *Id.*

³⁵ This was the source of Justice Powell’s dissent, who wrote the majority in *Maher v. Roe* and who repudiated the idea in both cases that the state was interfering with the decision to have an abortion by refusing to fund it. *See* 428 U.S. at 128-29 (Powell, J., dissenting).

³⁶ *Beal v. Doe*, 432 U.S. 438 (1977); *Maher v. Roe*, 432 U.S. 464 (1977). It also heard *Poelker v. Doe*, 432 U.S. 519 (1977), which held that a city-owned public hospital (also in Missouri) could refuse to provide abortion services without violating the Equal Protection Clause based upon the analysis in *Maher v. Roe*. Interestingly, it appears that this trio of cases marked a divergence between Justice Blackmun and Justice Powell. Though Justice Powell supported Justice Blackmun’s analysis in *Roe v. Wade*, his majority opinion in *Maher* and its companion cases departed from Justice Blackmun’s view of the *Roe* precedent. *See* Linda Greenhouse, *How the Supreme Court Talks About Abortion: The Implications of a Shifting Discourse*, 42 SUFFOLK U. L. REV. 41, 41-42, 49-50 (2008).

³⁷ Pennsylvania limited payment for abortions to those certified as “medically necessary” by three physicians, where medical necessity equated to a threat to the health of the mother, defects of the fetus, rape, or incest. *See Beal v. Doe*, 432 U.S. at 441-42. The Court held that the Medicaid Act did not require Pennsylvania to pay for all abortions that were technically legal under Pennsylvania law, even though the Medicaid Act required states to provide access and payment for certain categories of medical care. *See id.* at 444; *see also* 42 U.S.C. §1396d(a). The Court called abortion “unnecessary though perhaps desirable medical services,” which the state was not obliged to cover. *See id.* at 444.

³⁸ *Maher*, 432 U.S. at 466.

³⁹ Justice Powell wrote:

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

Id. at 474-75.

⁴⁰ *See id.* at 479. Justice Powell urged that “There is a basic difference between direct state interference with a protected activity and state encouragement of an alternative activity consonant with legislative policy. Constitutional concerns are greatest when the State attempts to impose its will by force of law; the State's power to encourage actions deemed to be in the public interest is necessarily far broader.” *Id.* at 476.

much higher than paying for abortion, the state’s decision was rational because the state may encourage “normal” childbirth.⁴¹ The Court stated in dicta that it believed historical mores supported the state’s interest in encouraging childbirth, writing: “a State may have legitimate demographic concerns about its rate of population growth. Such concerns are basic to the future of the State and in some circumstances could constitute a substantial reason for departure from a position of neutrality between abortion and childbirth.”⁴² This dicta suggests that maternity may be imposed on women who depend on government funds for medical care,⁴³ a Victorian notion that also implicates the fundamental right to procreate.⁴⁴

Further, even though states have always had some flexibility in the Medicaid program, allowing states to shun one particular medical procedure that would otherwise be covered as a physician service or an outpatient hospital service ignored the statutory framework of the Medicaid Act⁴⁵ as well as the purpose of the Medicaid Act, to ensure that indigent citizens would have equal access to medically necessary services.⁴⁶ Medicaid was created to secure medical assistance for individuals “whose income and resources are insufficient to meet the costs of necessary medical services.”⁴⁷ Every woman seeking abortion must have the help of a physician to pursue her medical goals, just as a woman giving birth seeks medical care for prenatal services and labor and delivery.⁴⁸ Denying Medicaid payment, then, effectively foreclosed indigent women from obtaining this medical intervention.⁴⁹ The Court’s analysis separated the right to obtain abortion from realization of the right, as Justice Blackmun noted, an analysis that reflects the greater includes the lesser theory of spending.⁵⁰ At the time, very little jurisprudence existed regarding the Spending Clause, but *Maher* generated a line of cases that would support this philosophy.

The misconceptions regarding the Medicaid program and individuals’ reliance on it continued a few years later in *Harris v. McRae*.⁵¹ Decided in 1980, *McRae* involved a statutory issue regarding whether states were required to fund medically necessary abortions after the Hyde Amendment prevented use of federal funding. The Court analyzed the most restrictive version of the Hyde Amendment,⁵² a provision that only permitted use of Medicaid funds as

⁴¹ The District Court found this financial decision on the part of the state to be irrational. *See id.* at 468.

⁴² *Id.* at 479, n.11.

⁴³ The district court noted “To sanction such a justification would be to permit discrimination against those seeking to exercise a constitutional right on the basis that the state simply does not approve of the exercise of that right.” *Roe v. Norton*, 408 F. Supp. 660, 664 (1975).

⁴⁴ *Skinner v. Oklahoma*, 316 U.S. 535 (1942); *cf. Buck v. Bell*, 274 U.S. 200 (1927).

⁴⁵ The Medicaid Act is codified at 42 U.S.C. § 1396 et seq.

⁴⁶ *See Stevens & Stevens, supra* note 19, at 57.

⁴⁷ *See id.* at 57. *See also* 42 U.S.C. § 1396.

⁴⁸ *See* Sylvia A. Law, *Childbirth: An Opportunity for Choice that Should Be Supported*, 32 N.Y.U. REV. L. & SOC. CHANGE 345, 372-76 (2008) (describing how definitions of medical necessity and courts’ interpretation of that terminology is at odds with women’s health needs).

⁴⁹ *See Maher*, 432 U.S. at 454 (Marshall, J., dissenting). Justice Marshall revealed the Court’s legerdemain, stating: “As the Court well knows, these regulations inevitably will have the practical effect of preventing nearly all poor women from obtaining safe and legal abortions.” *Id.* Justice Marshall also noted the disparate impact on non-white women of such policies and argued that the Court’s equal protection analysis was flawed. *See id.* at 458-60.

⁵⁰ *See id.* at 462 (Blackmun, J., dissenting).

⁵¹ *Harris v. McRae*, 448 U.S. 297 (1980).

⁵² *Id.* at 302-303.

payment when the life of the mother was endangered.⁵³ The Court found that states were not required to pay for services that the federal government would not fund, Medicaid being a cooperative federalism program that involves matching funds, not unfunded mandates.⁵⁴

Evaluating the constitutionality of the Hyde Amendment, the Court relied heavily on its decision in *Maher*. Justice Stewart compared the Hyde Amendment to Connecticut’s funding moratorium and reiterated that refusal to fund does not place an “obstacle” in the path of a woman seeking to terminate pregnancy.⁵⁵ Instead, the majority determined that the Hyde Amendment, like the law at issue in *Maher*, encouraged an activity “deemed in the public interest.”⁵⁶ Even though the Court reiterated the legitimacy of the *Roe* decision, it held that refusal to fund should not to be equated with a “penalty” even when medically necessary services are not covered.⁵⁷ The Court also refused to consider that the Hyde Amendment was a violation of the Equal Protection Clause.⁵⁸

Justice Brennan’s dissent noted, however, that refusal to pay is a deliberate effort to prevent the exercise of a constitutionally protected right.⁵⁹ Justice Brennan described the Hyde Amendment as a withdrawal of funds for medically necessary services that would otherwise be paid for by Medicaid.⁶⁰ In other words, the decision to provide federal spending for healthcare had already been made, and abortions had been paid for by Medicaid until the Hyde Amendment’s passage. The Court did not evaluate the legislative history of the amendment, which supported Justice Brennan’s assertion that in both

design and effect it serves to coerce indigent pregnant women to bear children they would otherwise elect not to have... When viewed in the context of the Medicaid program to which it is appended, it is obvious that the Hyde Amendment is nothing less than an attempt by Congress to circumvent the dictates of the Constitution and achieve indirectly what *Roe v. Wade* said it could not do directly.⁶¹

Representative Hyde unequivocally stated that he would end all abortions if he could, but that the Medicaid Act was the only way that he could flex his legislative muscle.⁶² Representative Hyde also subscribed to and advanced the Victorian more that a woman naturally should want to be a mother, stating: “When a pregnant woman, who should be the natural protector of her unborn

⁵³ This was an important difference from *Maher*, in which Connecticut was paying for so-called medically necessary abortions. The Hyde Amendment, in contrast, does not pay for medically necessary abortions except for a few limited circumstances, *i.e.* the life of the mother is endangered or cases of rape or incest.

⁵⁴ *McRae*, 448 U.S. at 309-10. This would never have been a strong argument, given that Medicaid is a federal matching fund program. The plaintiffs might have been more successful arguing that the Hyde Amendment was inconsistent with the statutory goals of Medicaid, but nothing can be gained from playing armchair litigator.

⁵⁵ *Id.* at 314.

⁵⁶ *Id.* at 315.

⁵⁷ *Id.* at 317, n.19. The Court wrote: “A refusal to fund protected activity, without more, cannot be equated with the imposition of a “penalty” on that activity.” The Court also reiterated the *Maher* holding that poverty is not a suspect classification and thus no equal protection clause violation occurred because legitimate state interests are served in protecting potential life that are rationally expressed by encouraging childbirth. *Id.* at 322-23.

⁵⁸ 448 U.S. at 332-33. A number of scholars have critiqued the decision based upon its equal protection analysis (or lack thereof). *See, e.g.*, Ruth Colker, *Equality Theory and Reproductive Freedom*, 3 TEX. J. WOMEN & L. 99 (1994); Siegel, *supra* note 1, at 357-58; Sunstein, *supra* note 27, at 617-19.

⁵⁹ 448 U.S. at 330 (Brennan, J., dissenting).

⁶⁰ *Id.* at 329.

⁶¹ *Id.* at 330-31.

⁶² Statement of Representative Henry Hyde, House CONG. REC., June 17, 1977, at 19700.

child, becomes its deadly adversary, then it is the duty of this legislature to intervene... .”⁶³ The Court’s lack of analysis regarding this clear legislative history is startling, given how open the proponents of the Hyde Amendment were about their desire to stop women from exercising constitutional rights.⁶⁴ Representative Hyde even stated that he knew that women would not access abortion if Medicaid did not pay for it; yet, the Court did not mention or discuss this questionable funding condition.⁶⁵

Ten years later, *Rust v. Sullivan* continued the strained reasoning of *Maier* and *McRae*.⁶⁶ *Rust* involved Title X, which provides federal grants to public and nonprofit private entities willing to create family planning clinics that include services for low income populations, rather than Medicaid.⁶⁷ The statute forbids granting federal funds to “programs where abortion is a method of family planning.”⁶⁸ Petitioners challenged the regulations interpreting Title X, claiming they were outside the bounds of the statute and violated constitutional rights, including the Fifth Amendment Due Process Clause.⁶⁹ Describing the “authority” the government possesses under *McRae* and *Maier*, the Court held that Congress could refuse to fund both abortions and abortion counseling to promote childbirth.⁷⁰ Once again, the Court engaged in an unspoken greater includes the lesser analysis and described that this choice in funding is not the same as a penalty and leaves women in same position as if the federal funding did not exist at all.⁷¹ The Court also reiterated that the indigency that may preclude access to other family planning clinics or services is not a problem of the government’s making and thus not its duty to change.⁷² Chief Justice Rehnquist observed in a footnote that Congress has the power to ensure that funds are properly applied to the intended federal use and that the regulations worked in furtherance of that goal.⁷³ Chief Justice Rehnquist also recognized that, though it was not applicable in *Rust*, the unconstitutional conditions doctrine prevents the government from placing a condition on the recipient of federal funds that prevents engaging in constitutionally protected behavior, the very issue that was ignored in *McRae* and *Maier*.⁷⁴ As Justice Blackmun’s dissent noted, this is precisely the problem with the Title X ‘gag rule:’ the government forces Title X recipients to “distort” information so that the right to terminate

⁶³ *Id.* at 19701. This statement not only supports Justice Brennan’s dissent, it furthers arguments made by Professor Siegel, then-Judge Ginsburg, and other scholars that the equal protection clause is violated when the state interferes in reproductive decisions. See Siegel, *supra* note 1, at 326-28; see also Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade*, 63 N.C. L. REV. 375, 385 (1985). Sex-based discrimination had just begun to receive intermediate scrutiny in 1980, and the Court had resisted articulating a stricter standard of review for many years. See *Craig v. Boren*, 429 U.S. 190 (1976); see also LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 1561-65 (2d ed. 1988).

⁶⁴ As Professor Perry stated in his forceful deconstruction of *McRae*, it is clear that Congress was acting based on the idea that abortion is per se objectionable, which under the “narrowest coherent reading of *Roe*” is impermissible. Michael J. Perry, *Why the Supreme Court Was Plainly Wrong in the Hyde Amendment Case: A Brief Comment on Harris v. McRae*, 32 STAN. L. REV. 1113, 1123 (1980).

⁶⁵ Statement of Representative Henry Hyde, House CONG. REC., June 17, 1977, at 19,700-01.

⁶⁶ *Rust v. Sullivan*, 500 U.S. 173 (1991).

⁶⁷ 42 U.S.C. §§ 300 – 300a-6 (2003).

⁶⁸ 42 U.S.C. § 300a-6 (2003).

⁶⁹ 500 U.S. at 181.

⁷⁰ *Id.* at 192-93.

⁷¹ *Id.* at 193, 201.

⁷² Though *Rust* was heard after *South Dakota v. Dole*, discussed below, the Court did not engage in a Spending Clause analysis. *South Dakota v. Dole*, 483 U.S. 203 (1987).

⁷³ 500 U.S. at 195, n.4.

⁷⁴ *Id.* at 196-97.

pregnancy cannot be exercised.⁷⁵ In Justice Blackmun’s view, this was no different than if the federal government “banned abortions outright.”⁷⁶

A year after *Rust*, the Court decided *Planned Parenthood of Southeastern Pennsylvania v. Casey*,⁷⁷ which also drew on the faulty foundation of *Maher* and *McRae*. Though *Casey* was not a Spending Clause-related case, its analysis of governmental interference with abortion is pertinent to the current discussion. Justice O’Connor’s plurality reduced the standard of review from strict scrutiny to an “undue burden” analysis that had been used in dicta in prior abortion cases but that had not become the official standard of review. In so doing, the joint opinion attempted to describe what would constitute an undue burden by the state on a woman’s exercise of her privacy right, relying in part on *Maher* and *McRae*: “The fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it.”⁷⁸ As with *Maher* and in *McRae*, the *Casey* Court ignored the burden placed on a woman of no means when abortion becomes more expensive as well as the state’s intent to “strike at the right itself.”⁷⁹ Paradoxically, Justice O’Connor further explained: “finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.”⁸⁰ This language upheld such state obstacles as a twenty-four hour waiting period between information regarding abortion and performance of the procedure, using analysis much the same as that in *Maher* and *McRae*.⁸¹

Decided fifteen years later by the newly composed Roberts Court, *Gonzales v. Carhart* built on the foundation of the aforementioned precedents.⁸² Again, though not a spending case, *Carhart II* is relevant to the spending analysis for continuing the reasoning begun in *Maher* and

⁷⁵ A case with a similar issue, *Legal Services Corporation v. Velazquez*, was decided in quite the opposite manner. *Legal Services Corporation v. Velazquez*, 531 U.S. 533 (2001). In *Velazquez*, the Court held that despite the broad power that accompanies federal funding, the LSC could not be prohibited from representing clients who presented challenges to the welfare program as a whole (though clients with specific appeals could be represented). The Kennedy majority attempted to distinguish itself from *Rust* by describing limits on LSC counsel as limits on speech that completely prevented welfare recipients from challenging certain aspects of welfare law and policy, which the majority found improperly impacted the justice system as a whole and completely prevented the plaintiffs from making certain legal arguments. The majority argued that the women who seek reproductive health counseling at Title X centers had other avenues to learn of abortion and related services and thus distinguished *Rust* as inapposite. *See id.* at 546-47. The Court’s arguments are unpersuasive, as the impositions on the legal profession are equally troubling for the medical profession. Further, the funding restrictions operate in virtually the same manner. Though Justice Scalia’s dissent urged that this analysis militated toward finding that the restrictions on the LSC were permissible, it seems that the opposite conclusion is even more persuasive – *Rust* was wrongly decided. *See id.* at 553-55 (Scalia, J., dissenting).

⁷⁶ *Id.* at 218 (Blackmun, J. dissenting). Consistent with his majority opinion in *Roe v. Wade*, Justice Blackmun focused on the intrusion into the physician-patient relationship and the key role a physician plays in a woman’s decision to continue or terminate a pregnancy. *Id.* at 218.

⁷⁷ 505 U.S. 833 (1992).

⁷⁸ *Id.* at 874.

⁷⁹ Conspicuously, the law at issue was called the Pennsylvania Abortion Control Act, and the state had been attempting to limit access to abortion since *Roe* was decided. *See* Brief for Petitioners and Cross-Respondents at 2-5, *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (describing the many incarnations of the Pennsylvania Abortion Control Act and the many federal court decisions that struck down Pennsylvania’s attempts to prevent abortion).

⁸⁰ 505 U.S. at 877-78.

⁸¹ *Id.* at 885-86.

⁸² 550 U.S. 124, 127 S. Ct. 1610 (2007).

McRae. Justice Kennedy “assumed” that *Roe* and *Casey* remained good precedent, and in so doing, also relied on the obstacle language from *Casey* that drew from *Maher* and *McRae*.⁸³ Thus, the refusal to recognize the kind of state action that can result in an obstacle to the individual who seeks to exercise constitutionally protected rights continued.

C. Trends

The line of spending-related caselaw exposes at least two trends. First, in contrast to the nearly constant tinkering with the *Roe* precedent, the doctrine from *Maher* and *McRae* has remained remarkably steady. This unwavering reliance on *Maher* and *McRae* has permitted the Court to continue a fallacy in its analysis, that the government does not unduly burden a woman’s privacy right by refusing to pay for abortion in federal spending programs while favoring childbirth. The Court ignored clear legislative history in its analysis of the state’s intent when analyzing “undue burden,” which has allowed Congress and the states to burden this particular right in ways that likely would be impermissible for other fundamental rights. Such an analysis can exist by virtue of the greater includes the lesser theory and is reinforced by continued interest in the positive/negative rights dichotomy. Both theories ignore the reality of modern government, which rides not only on the deterrent effect of criminal punishment but also on the coercive effect of pervasive funding.

Second, the Court’s acceptance of these sister precedents affords Congress exceptionally broad power under the Spending Clause to use conditions on spending to prohibit use of federal funds for abortion, thereby influencing state policy, private policy, and the rights of both physicians and individual women. But the congressional authority created by *Maher* and *McRae* has grown beyond its original context, as Congress has created not only pure funding statutes that prohibit payment for abortion, but also conscience clause statutes that prohibit recipients of federal funds from controlling the behavior of their healthcare providers. The funding statutes that are the legacy of *Maher* and *McRae* are explored next.

III. Legislative Legacy

A surprising number of conditional spending statutes have sprouted from the fertile soil of *Maher* and *McRae*. The first type are “pure funding statutes,” meaning laws that forbid use of federal funds for abortion procedures and/or abortion counseling. The second type are “conscience clause funding statutes,” meaning laws that forbid recipients of federal funds from discriminating against those healthcare providers who refuse to participate in abortion or abortion counseling.⁸⁴ The two varieties of statute have given *Maher* and *McRae* broad

⁸³ *Id.* at 1626-27.

⁸⁴ Some urge that conscience clause statutes are an important, or at least legitimate, method for protecting the First Amendment rights of healthcare providers. See, e.g., Kent Greenawalt, *Objections in Conscience to Medical Procedures: Does Religion Make a Difference?*, 2006 U. ILL. L. REV. 799, 818-25 (2006) (arguing that religious exemptions reflected in conscience clauses tend to be constitutionally legitimate but that more objection clauses may be unprotected); Maxine M. Harrington, *The Ever-Expanding Health Care Conscience Clause: The Quest for Immunity in the Struggle between Professional Duties and Moral Beliefs*, 34 FLA. ST. U.L. REV. 779, 788 (2007) (providers should be able to refuse to provide healthcare procedures because of moral objections, but conscience clause legislation should balance the interests of the patient); Robert K. Vischer, *Conscience in Context: Pharmacist Rights and the Eroding Moral Marketplace*, 17 STAN. L. & POL’Y REV. 83 (2006) (urging use of the market to balance the rights of pharmacists who have moral objections and patients who seek access to legal

influence that may reach beyond the abortion realm into general reproductive services, including contraception and sterilization, for both women in public programs and women who have private insurance. These laws also reveal the breadth of Congress’s power to place conditions on federal funds in ways that surely run afoul of current Spending Clause jurisprudence and reflect the phenomenal permissiveness of the greater includes the lesser model for conditional spending statutes. Moreover, these statutes reach beyond the Medicaid program into programs such as Medicare (the social insurance program for the elderly) to place limitations on healthcare providers in unexpected ways.

A. Pure Funding Statutes

The Hyde Amendment, a short but powerful rider to federal appropriations legislation, affects two major conditional spending programs, Medicaid and the State Children’s Health Insurance Program (SCHIP).⁸⁵ The Hyde Amendment was first passed as a rider to the annual Department of Health, Education, and Welfare and Department of Labor appropriations bill in 1976 after the 1973 decision in *Roe v. Wade*.⁸⁶ The Hyde Amendment has been renegotiated and modified each year, which has resulted in the exceptions for rape, incest, and health having been dropped, added, and dropped again, but it is always attached to the funding for the Department of Health and Human Services (DHHS, the agency responsible for Medicare, Medicaid, and SCHIP).⁸⁷ The current version of the amendment includes exceptions for the life of the mother, rape, and incest, but not for the health of the mother or for fetal abnormalities.⁸⁸ Representative Hyde stated during the floor debate: “I would certainly like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle class woman, or a poor woman. Unfortunately, the only vehicle available is the HEW medicaid [sic] bill.”⁸⁹ This language is important to understand because it has been attached to several other federal spending programs, either written into the legislation creating the program or added by riders to appropriations bills.

1. Medicaid

prescriptions); Leslie C. Griffin, *Conscience and Emergency Contraception*, 6 HOUS. J. HEALTH L. & POL’Y 299 (2006).

⁸⁵ 42 U.S.C. § 1396 (2006) (Medicaid); 42 U.S.C. § 1397ee(c)(1) (2006) (SCHIP).

⁸⁶ Pub. L. No. 94-439, §209, 90 Stat. 1418 (1976).

⁸⁷ See, e.g., Pub. L. No. 108-447, div. F, tit. V, §§507(a), 508(a) (2004) (prohibiting use of federal funds for Health and Human Services programs, including Medicaid, except in the case of rape, incest, or the life of the mother is endangered; notably, prohibitions on use of federal funds pervade this public law, including prohibitions on use of funds for abortions for the Department of Justice, for the military, for overseas projects, and for federal employee health benefits); Pub. L. No. 103-112, §509, 107 Stat. 1082, 1113 (1993); Pub. L. No. 98-619, § 204 (1984); Pub. L. No. 97-12, § 402 (1981); see also 42 C.F.R. §§ 441.200-208.

⁸⁸ 42 C.F.R. § 441.200.

⁸⁹ Statement of Rep. Henry Hyde, CONG. REC., House, 19698, 19700 (June 17, 1977). Representative Hyde retired at the end of 2006 and passed away in late 2007. Despite Representative Hyde’s retirement at the end of 2006, the Hyde Amendment has not been repealed or rejected by Congress yet. Some believe that Democrats have been afraid to repeal the amendment because it would highlight the Medicaid program in a way that could lead to general reductions in Medicaid funding. See Heather D. Boonstra, *The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States*, GUTTMACHER POLICY REVIEW, 16 (2007), <http://www.guttmacher.org/pubs/gpr/10/1/gpr100112.pdf>.

As was described above, Medicaid is a classic cooperative federalism program by which the federal government agrees to match funds that states spend to provide “medical assistance” to certain very poor citizens pursuant to a “State plan.”⁹⁰ Medicaid is structured to cover the needs of certain “categorically” poor, such as the blind, disabled, elderly, children, and pregnant women, and thus the program only covers about 40% of all of the nation’s poor.⁹¹ The Medicaid Act obligates states to provide medical assistance for enrollees in certain categories of medical care, and the states generally must provide the same benefits to all enrollees, a funding condition known as comparability.⁹² Among the items that must be covered are the cost of care and/or services for both outpatient hospital services and physician services for all Medicaid enrollees.⁹³ Despite these requirements, the Hyde Amendment has attached as a condition on the federal funding for Medicaid since 1977; though it has not been codified in the Medicaid Act,⁹⁴ the ban is written into the regulations for Medicaid.⁹⁵ Technically the Hyde Amendment only addresses the DHHS distribution of federal funds, it does not prohibit states from paying for abortion. However, states have no obligation to pay for those services that the federal government will not fund (under *McRae*),⁹⁶ rendering the Hyde Amendment effectively a condition on federal spending.

Some basic statistics highlight the impact of a funding restriction such as the Hyde Amendment. About 12% of all women of childbearing age were enrolled in Medicaid as of 2006, and women comprise 69% of the adult beneficiaries in Medicaid.⁹⁷ Of the adult women enrolled in Medicaid, nearly two-thirds are of child-bearing age.⁹⁸ Medicaid pays for 41% of all births nationally and more than half of the births in certain states.⁹⁹ Medicaid covers prenatal care, childbirth, and postnatal services, and coverage of pregnant women is the category with the highest financial threshold for enrollees (at 133% of the federal poverty level).¹⁰⁰ Medicaid also funds family planning through an enhanced federal match to states, resulting in Medicaid covering 61% of all federal spending for family planning, though family planning cannot cover abortion or counseling regarding abortion.¹⁰¹ In 2008, the federal poverty level for one person was \$10,400; \$3,600 is added for each additional person in a household.¹⁰² The women who

⁹⁰ 42 U.S.C. § 1396 et seq. (2006).

⁹¹ 42 U.S.C. § 1396a(a)(10)(A).

⁹² 42 U.S.C. § 1396a(a)(10)(B) (2006). Even states with special waivers (called section 1115 waivers) have to adhere to comparability, though under a recent Medicaid modification, states with approved plans called DRA benchmark plans need not. *See* 42 U.S.C. § 1396u-7.

⁹³ *See* 42 U.S.C. § 1396d(a)(2) & (a)(4).

⁹⁴ The abortion restriction was included in the Deficit Reduction Act provisions that permit states to use certain kinds of managed care for Medicaid populations. *See* 42 U.S.C. § 1396u-2.

⁹⁵ 42 C.F.R. § 441.200.

⁹⁶ *McRae*, 448 U.S. at 308.

⁹⁷ *See* Heather d. Boonstra, *The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States*, GUTTMACHER POLICY REVIEW, 12 (2007), <http://www.guttmacher.org>; *Medicaid’s Role for Women*, Kaiser Family Foundation, 1 (2007), http://www.kff.org/womenshealth/upload/7213_03.pdf.

⁹⁸ *See* Medicaid’s Role for Women at 2.

⁹⁹ *See id.*

¹⁰⁰ 42 U.S.C. § 1396a(l). Many states cover pregnant women up to 185% of the federal poverty level, as permitted by federal law. *See id.*

¹⁰¹ *See* Medicaid’s Role for Women at 2. The enhanced match is 90 cents to every 10 cents states spend; the usual federal match is between 50% and 76% of the state’s spending on its Medicaid enrollees depending on the state and its poverty level. *See also* 42 U.S.C. § 1396d(a)(4)(C).

¹⁰² *See* 73 Fed. Reg. 3971 (2008) (delineating federal poverty guidelines for the Department of Health and Human Services).

qualify for Medicaid are extremely poor; they can barely cover the basic necessities such as housing and food, let alone medical care.

Though Medicaid is not specifically a women’s healthcare program, many women depend on Medicaid for access to medical care, and the policies implemented through Medicaid spending have a disproportionate impact on women in general.¹⁰³ Women enrolled in Medicaid tend to be not only of childbearing age and poor, but also less educated, minorities, and parents.¹⁰⁴ As of 2004, 5% of white women were covered by Medicaid, while 12% of Hispanic women and 14% of African-American women were Medicaid enrollees.¹⁰⁵ Conditions placed on use of Medicaid funds are likely to have a greater impact on women of color. This was one of the many concerns expressed by the members of the House that opposed the Hyde Amendment. Representative Parren Mitchell, speaking on behalf of the Black Caucus, stated:

There is simply no denying that the effect of the Hyde amendment would be to exclude only those of limited financial means from access to legal abortions. Medicaid funds are the primary Federal moneys used to pay for abortions, and according to [HEW], some 250,000 to 300,000 abortions were paid for with federal funds in 1975. ... the Hyde amendment is discriminatory legislation. ... Black women are disproportionately represented among the poor and are relatively more likely to need the assistance of Medicaid to obtain the same abortion that their wealthier sisters will be able to obtain in any case.¹⁰⁶

Though this statement was made in 1977, it remains true more than thirty years later.

Before the Hyde Amendment was passed, just thirteen states had enacted abortion funding bans; but by 1979, forty states had terminated state coverage for abortions not covered by federal Medicaid matching funds.¹⁰⁷ Currently, seventeen states use their own funds to provide coverage for abortions that may not be paid for with federal funds.¹⁰⁸ Before Congress ended federal funding, Medicaid paid for almost one-third of all abortions – about 300,000 annually; after, the federal government has paid for virtually none.¹⁰⁹ Even though rates of abortion have been decreasing nationally, the trends among poor women and women of color tell a different story.¹¹⁰ The rate of abortion has been increasing for all poor women since 1994, and

¹⁰³ When the Hyde Amendment was passed, the House contained only eighteen female representatives: “I would say that if there were 417 women in the House instead of 417 men, and if there were 18 men instead of 18 women in this House, that we would not be faced with this amendment today.” Statement of Representative Holtzman, CONG. REC. 19699, 19708 (June 17, 1977).

¹⁰⁴ See Medicaid’s Role for Women at 1.

¹⁰⁵ See *Women and Healthcare: A National Profile*, Kaiser Family Foundation, 16 (2005), <http://www.kff.org/womenshealth/7336.cfm>. Interestingly, 38% of Hispanic women were then uninsured, compared to 17% of African-American women and 13% of white women, perhaps indicating an outreach problem.

¹⁰⁶ Statement of Representative Parren J. Mitchell, CONG. REC. 19699, 19710-11 (June 17, 1977).

¹⁰⁷ Marlene Gerber Fried, *The Hyde Amendment: 30 Years of Violating Women’s Rights*, 2, available at http://www.overbrook.org/newsletter/06_11/pdfs/hrs/Civil_Liberties_And_Public_Policy_Program.pdf (last visited Mar. 8, 2009).

¹⁰⁸ See *Abortion in the U.S.: Utilization, Financing, and Access*, Kaiser Family Foundation, 1 (2008), <http://www.kff.org>.

¹⁰⁹ See Statement of Representative Weiss, CONG. REC., House, 19698, 19709 (June 17, 1977). See also Adam Sonfield, Casey Alrich, & Rachel Benson Gold, *Public Funding for Family Planning, Sterilization and Abortion Services, FY 1980–2006*, Guttmacher Institute, 18 (2008) (the federal government contributed to the cost of 191 abortion procedures in 2006, and states paid for the remainder of the 177,000 government-funded abortions).

¹¹⁰ Justice Marshall predicted that they would in *Maher*, writing:

It is no less disturbing that the effect of the challenged regulations will fall with great disparity upon women of minority races. Nonwhite women now obtain abortions at nearly twice the rate of whites, and it

black and Hispanic women have abortions at higher rates than white women.¹¹¹ Relatedly, between 1994 and 2001, the unintended pregnancy rate rose for blacks, Latinas, and poor women, which made them more likely to turn to abortion.¹¹² Women of color and poor women are more likely to delay obtaining an abortion due to the effort to raise money; an abortion in the first trimester on average costs \$430, whereas in the second trimester it costs an average of \$1260.¹¹³ Given the current federal poverty level, a single woman enrolled in Medicaid can make no more than \$866 per month to remain qualified for Medicaid. As the procedure has become more concentrated among the women who are enrolled in Medicaid, it has become more clear that women must divert money for essentials such as rent, food, utilities, clothing, and other necessities in order to be able to financially access the procedure.¹¹⁴

2. SCHIP

SCHIP is a spending program that provides federal funds to states to provide healthcare coverage to low-income uninsured children and their families.¹¹⁵ SCHIP is a federal block grant program, though, so its structure is notably different from Medicaid’s. Whereas Medicaid is an entitlement for both the state and the individual, SCHIP limits the federal funds provided to states and is specifically not an entitlement for its enrollees.¹¹⁶ Also, whereas Medicaid covers several categories of eligible enrollees, SCHIP was written specifically to cover children who do not qualify for Medicaid but who are near-poor (states decided to cover their parents too).¹¹⁷ Finally, whereas Medicaid has no limit to the federal match, SCHIP is capped at a set federal dollar amount each year.

The Hyde Amendment would have affected SCHIP as it affects Medicaid; the Amendment forbids DHHS to spend federal funds on abortion in most circumstances, and DHHS administers SCHIP. However, when SCHIP was enacted in 1997, the Hyde language was written into the legislation rather than depending on an annual rider.¹¹⁸ As with Medicaid, SCHIP funds may not be used for abortion except in extraordinary circumstances: “any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.”¹¹⁹

Many of the demographics that exist within Medicaid are also true for SCHIP. Though teenage pregnancy had been declining from 1990 until 2004, an increase in teen pregnancy

appears that almost 40% of minority women ... are dependent upon Medicaid for their health care. Even if this strongly disparate racial impact does not alone violate the Equal Protection Clause, “at some point a showing that state action has a devastating impact on the lives of minority racial groups must be relevant.”

Maheer v. Roe, 432 U.S. at 459-60 (Marshall, J., dissenting) (citations omitted).

¹¹¹ See *Abortion in the U.S.*, *supra* note 108, at 1. A 2002 study showed African-American women’s abortion rates to be 49/1000 and Hispanic women’s rates to be 33/1000, whereas white women’s rate was 13/1000. *See id.*

¹¹² See Heather D. Boonstra, Rachel Benson Gold, Cory L. Richards, Lawrence B. Finer, *Abortion in Women’s Lives*, Guttmacher Institute, 26-28 (2006), <http://www.guttmacher.org>.

¹¹³ *See id.* at 29; *Abortion in the U.S.*, *supra* note 108, at 1.

¹¹⁴ Geography and state waiting periods add additional financial hurdles. *See Colker, supra* note 58, at 116-20 (discussing the role poverty should play in reproductive rights analysis).

¹¹⁵ 42 U.S.C. § 1397aa (2006).

¹¹⁶ 42 U.S.C. § 1397bb(b)(4) (2006).

¹¹⁷ 42 U.S.C. § 1397aa(a) (2006).

¹¹⁸ 42 U.S.C. § 1397ee(c)(1) (2006).

¹¹⁹ *Id.*; 42 U.S.C. § 1397jj(a)(16) (2006).

occurred between 2005-2006.¹²⁰ Teen abortion rates have also been falling, but both the pregnancy rates and the abortion rates are higher among African-American and Hispanic teens.¹²¹ Again, many of the statistics and demographics are reminiscent of Medicaid. The SCHIP pure funding limitations are potentially more constant, because the SCHIP funding limitation is written as a condition of receiving federal funds within the SCHIP statute itself. Also, the restrictions in SCHIP are a deliberate limitation on minors’ access to reproductive health services, a group that would have even more difficulty accessing healthcare than most.

3. Other Federal Programs

Legislators have added Hyde-style language to other appropriations bills, thereby denying federal funding for abortion coverage in many varied programs such as federal employees,¹²² federal prisoners,¹²³ military personnel and their families,¹²⁴ Native Americans,¹²⁵ Peace Corps volunteers,¹²⁶ and foreign aid programs.¹²⁷ Many of the spending limitations that can be described as pure funding statutes are appropriations bill riders, much like the Hyde Amendment itself.

Hyde-style language has had some severe results. For example, the healthcare program for military members and their families, known as the TRICARE program,¹²⁸ contains the following prohibition: “[f]unds available to the Department of Defense may not be used to perform abortions except where the life of the mother would be endangered if the fetus is carried to term.”¹²⁹ The TRICARE regulations clarify that abortions performed in the case of “fetal abnormalities” -- including anencephaly (the complete lack of a cranial cavity) -- are not covered.¹³⁰ A recent case highlights the brutal implications of this limitation. Mrs. Britell was

¹²⁰ See *Sexual Health of Adolescents and Young Adults in the United States*, Kaiser Family Foundation, 1, http://www.kff.org/womenshealth/upload/3040_04.pdf.

¹²¹ See *id.*

¹²² Federal Employees Health Benefits Program funding facilitates this limitation. See Consolidated Appropriations Act, Pub. L. No. 110-161, §615-616, 121 Stat. 2015 (2008) (only allowing payment in instances of life endangerment, rape, or incest).

¹²³ Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, §202- 204. These Department of Justice funding provisions encompass both pure funding and conscience clause funding, as they provide that the funds cannot be used to provide for abortion except to save the life of the mother or in instances of rape, but also that prison guards need not participate in the transportation of female prisoners for such medical services if it contradicts their personal beliefs. See *id.*

¹²⁴ TRICARE, 10 U.S.C. Ch. 55; 10 U.S.C. § 1093(a) (2006).

¹²⁵ Indian Health Service Act, 25 U.S.C. § 1676 (2008).

¹²⁶ Foreign Operations, Export Financing, and Related Programs Act, Pub. L. No. 109-102, 119 Stat. 2184 (2005).

¹²⁷ See, e.g., 22 U.S.C. § 2151b(f) (2006) (referred to as the “global gag rule” or the “Mexico City Policy”). President Obama issued an executive order during his first week in office to reverse the Bush Administration’s policy of preventing use of foreign aid funds to organizations that provide counseling about or services for abortion. See Rob Stein and Michael Shear, *Obama Lifts Global Abortion ‘Gag Rule,’* WASH. POST, Jan. 23, 2009. The so-called “Mexico City Policy” started with President Reagan, was rescinded by President Clinton, reinstated by George W. Bush, and has now been rescinded again by President Obama.

¹²⁸ 10 U.S.C. § 1072(7) (2006) (defining the TRICARE program).

¹²⁹ 10 U.S.C. § 1093(a) (2006).

¹³⁰ 32 C.F.R. § 199.4(e)(2) (2003). Anencephaly occurs when the fetus’s skull does not form and thus only a brain stem, at most, develops. Anencephaly is always fatal, usually within a week of birth. Because the brain does not form, anencephaly can jeopardize a woman’s life, as the hormones that trigger labor often are not secreted by the fetus. *Britell v. United States*, 204 F.Supp.2d 182, 185-86 (D. Mass. 2002). The regulation provides:

the wife of an Air National Guard captain and in the midst of a highly desired pregnancy but learned that the fetus was anencephalic. She was advised by her physician that anencephaly is untreatable and always fatal, and that she could terminate the pregnancy or carry to term and be induced, but either way the fetus would not survive. After consulting with her husband, her priest, grief counselors, and others, she decided to terminate the pregnancy but learned after the induced-labor procedure that TRICARE would not pay for the abortion.¹³¹ As the district court noted, TRICARE pays for all medically necessary healthcare services but excludes abortion, including for severe fetal abnormalities, from the payment scheme.¹³² Mrs. Britell argued that the TRICARE regulation was unconstitutional as applied to her because the fetus had no potential life, and therefore no state interest in life could be furthered. This tactic opened the prospect for a federal court to reconsider the facial challenge analyzed in *McRae*. The district court agreed, holding that even applying the rational basis review standard from *McRae*, the regulation was impermissible, as no legitimate state interest is served by forcing a woman to continue pregnancy with a brain-absent fetus.¹³³

On appeal, the Federal Circuit reversed and held that the government acted pursuant to the legitimate interest in promoting potential life.¹³⁴ Relying on *McRae* and *Maher*, the appellate court determined that the TRICARE regulation paralleled the Hyde Amendment closely and, like that law, did not violate the Equal Protection Clause because it passed rational basis review.¹³⁵ The circuit court, in so holding, essentially determined that anencephaly is not always terminal, despite scientific evidence and trial court findings to the contrary.¹³⁶ The *Britell* holding has traction, though, because of *McRae* and *Maher*.¹³⁷ *Britell* also displays the deferential analysis that has occurred in these cases. Even assuming rational basis review is the correct standard, it

Abortion. The statute under which CHAMPUS operates prohibits payment for abortions with one single exception--where the life of the mother would be endangered if the fetus were carried to term. Covered abortion services are limited to medical services and supplies only. Physician certification is required attesting that the abortion was performed because the mother's life would be endangered if the fetus were carried to term. *Abortions performed for suspected or confirmed fetal abnormality (e.g., anencephalic) or for mental health reasons (e.g., threatened suicide) do not fall within the exceptions permitted within the language of the statute and are not authorized for payment under CHAMPUS.* Note: Covered abortion services are limited to medical services or supplies only for the single circumstance outlined above and do not include abortion counseling or referral fees. Payment is not allowed for any services involving preparation for, or normal followup [sic] to, a noncovered abortion. The Director, CHAMPUS, or a designee, shall issue guidelines describing the policy on abortion.

Id. (emphasis added).

¹³¹ *Britell v. U.S.*, 204 F.Supp.2d 182, 183-84 (2002).

¹³² *See id.* at 183.

¹³³ *See id.* at 190-91. In concluding, the district court wrote: “Through the funding power the government seeks to encourage Britell and women similarly situated to suffer by carrying their anencephalic fetuses until they are born to a certain death. This rationale is no rationale at all. It is irrational, and worse yet, it is cruel.” *Id.* at 198.

¹³⁴ *Britell v. U.S.*, 372 F.3d 1370 (Fed. Cir. 2004).

¹³⁵ *See id.* at 1380-82.

¹³⁶ *See id.* at 1382.

¹³⁷ *See id.* at 1383-84. *See also* Perry, *supra* note 64, at 1120-21. Professor Perry wrote:

McRae is inconsistent with the narrowest possible reading of *Roe*. Note that under the narrowest coherent reading of *Roe*, government may not take action predicated on the view that abortion is per se morally objectionable. But that is not to say that government may not take action that has the effect of discouraging women from terminating their pregnancies. As far as *Roe* is concerned, such action is permissible so long as it is not predicated on the view that abortion is per se morally objectionable.

Id.

does not mean that courts must give the federal government a free pass on conditions on spending that are neither legitimate nor rational.¹³⁸

Another example of the pure funding statutes is the Public Health Services Act (Title X) Funding for Family Planning Clinics, which prohibits use of federal funds for abortion (or abortion counseling).¹³⁹ The “Gag Rule” upheld in *Rust v. Sullivan* (discussed above) states that “none of the funds appropriated under this subchapter shall be used in programs where abortion is a method of family planning.”¹⁴⁰ The purpose of Title X was to fund reproductive health (“family planning”) clinics, but those clinics can advise women of only certain reproductive medical options if the clinic accepts Title X funding. The clinics could provide such counseling so long as it is separated from the federal funding, but in reality clinics cannot create such a “Chinese wall” and often must forgo abortion counseling or referrals to secure much needed federal funding.

The pure funding statutes primarily act upon the enrollees in federal healthcare programs, rather than healthcare providers, though healthcare providers are affected too because they may be limited in the services they can provide to women. The dual effect on enrollees and healthcare providers highlights at least two concerns regarding the current jurisprudential status of conditional spending. The first is the idea that the federal government may place conditions on federal spending so long as the conditions are clear to the recipient, which generally means the state (discussed below). The second involves the greater includes the lesser theory that the federal government may impose regulations by virtue of spending that it could not otherwise implement. In the case of programs such as Medicaid, the state accepts the condition on behalf of its citizens, who have no ability to influence the decision. This underlines the disconnect between the existing conditional spending doctrine and its impact on individuals; if the greater includes the lesser theory holds that citizens can waive their rights when conditioned funds are offered, then the theory is also plainly incorrect because such waivers are made on their behalf by the states who negotiate with the federal government. The detachment is even more severe in the case of conscience clause funding statutes, which affect both the healthcare provider and the funding recipient in unanticipated ways.

B. “Conscience Clauses” Tied to Funding

Conscience clause funding statutes prevent healthcare providers that accept federal funds from “discriminating” against individuals who refuse to participate in abortion, sterilization, and related services. The conscience clause funding statutes further the reach of the Hyde-type language authorized by *Maher* and *McRae*. Though others have explored the First Amendment implications for conscience clause funding statutes,¹⁴¹ the use of conditions on federal funding to facilitate federal conscience clauses has not been explored. At least three major conscience

¹³⁸ The Supreme Court has occasionally struck down legislation under even its most deferential level of review. *See, e.g.,* *City of Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432 (1985); *Reed v. Reed*, 411 U.S. 677 (1973). Other examples exist, especially within equal protection clause jurisprudence.

¹³⁹ 42 U.S.C. § 300a-6.

¹⁴⁰ *Id.* If a patient asks about abortion, counseling and referrals may be provided pursuant to current regulations. *See* 42 C.F.R. § 59.5(a)(5). However, conscience clause funding limits may affect this regulation, as discussed below.

¹⁴¹ *See* note 84, *supra*.

clause funding statutes merit brief description, as they form the basis for a recently adopted regulation that greatly expanded the scope of conscience clause funding statutes.¹⁴²

The Church Amendment, which was originally part of Hill-Burton hospital funding, currently applies to the receipt of federal funds related to the Public Health Service Act, Community Mental Health Centers Act, and the Developmental Disabilities Services and Facilities Construction Act.¹⁴³ The Church Amendments clarify that federal fund recipients are not required to provide abortion or sterilization and prevent healthcare providers and other individuals in healthcare entities from experiencing discrimination by recipients of DHHS funds on the basis of their refusal to perform or participate in such healthcare services.¹⁴⁴ Notably, the Church Amendments protect both sectarian hospitals that oppose abortion and sterilization procedures and the employees of such hospitals who do not share their employers’ religious convictions.¹⁴⁵ In other words, the Church Amendments prevent a hospital from being forced by a patient, a doctor, or even a court to perform an abortion in its facility, but that hospital cannot discriminate against a medical professional who supports reproductive rights or who performs abortions or sterilization procedures outside the religious institution.¹⁴⁶

Likewise, the Danforth Amendment to the Public Health Service Act (Title X) prohibits “abortion-related discrimination in governmental activities regarding training and licensing of physicians.”¹⁴⁷ The Danforth Amendment prevents the federal government and state and local governments receiving federal funds from discriminating against healthcare providers that refuse to provide a range of abortion-related services and protects doctors, medical students, and health training programs.¹⁴⁸ This conscience clause funding statute also protects medical training programs from losing accreditation status (which would otherwise jeopardize federal funding) if they refuse to train residents in abortion and sterilization.¹⁴⁹ The Danforth Amendment intentionally protects refusals to participate in abortion or abortion-related services for any reason, it is not limited to religious objections.¹⁵⁰

Congress passed the Weldon Amendment (or “Hyde-Weldon Amendment”) in 2004 as part of an omnibus appropriations bill and, like the Hyde Amendment, the Weldon Amendment has become a rider to the annual HHS/Labor/Education appropriations legislation.¹⁵¹ The Weldon Amendment allows publicly funded institutions to refuse to provide abortion care and referrals. Like the Danforth Amendment, the Weldon Amendment is drafted with broad

¹⁴² Department of Health and Human Services, Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 78072 (Dec. 19, 2008).

¹⁴³ 42 U.S.C. § 300a-7 (2006) (named after its sponsor, Senator Frank Church of Idaho).

¹⁴⁴ 42 U.S.C. § 300a-7(b) (2006).

¹⁴⁵ 42 U.S.C. § 300a-7(c) (2006).

¹⁴⁶ The same legislative effort that created the Church Amendments in 1973 produced related pure funding statutes; for instance the Legal Services Corporation Act prevented use of federal funds to support litigation seeking access to “nontherapeutic” abortion, 42 U.S.C. § 2996f(b)(8), and the Foreign Aid Assistance Act prohibited the use of AID funds to “pay for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortion.” Pub. L. No. 93-189, § 2, 87 Stat. 714 (1973). Senator Church was involved in pushing all of these legislative maneuvers. See Leora Eisenstadt, *Separation of Church and Hospital: Strategies to Protect Pro-Choice Physicians in Religiously Affiliated Hospitals*, 15 YALE J. L. & FEMINISM 135, 145-46 (2003).

¹⁴⁷ 42 U.S.C. § 238n (2006).

¹⁴⁸ 42 U.S.C. § 238n(a) (2006).

¹⁴⁹ 42 U.S.C. § 238n(b) (2006).

¹⁵⁰ See Robin Fretwell Wilson, *The Limits of Conscience: Moral Clashes over Deeply Divisive Healthcare Procedures*, 34 AM. J. L. & MED. 41, 49 (2008).

¹⁵¹ Pub. L. No. 108-447, §508(d)(2005), 42 C.F.R. § 59.5(a)(5); Pub. L. No. 109-149, §508(d) (2006).

language that does not specify that a religious objection is the sole permissible objection, and it is not limited to the medical procedure of abortion, instead allowing all federally funded healthcare entities to refuse to “provide, pay for, provide coverage of, or refer for abortions.”¹⁵²

The Church Amendments, the Danforth Amendment, and the Weldon Amendment form the statutory foundation for a newly adopted regulation entitled “Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices In Violation of Federal Law.”¹⁵³ The “conscience regulation” requires all healthcare providers that receive federal funds to certify that they are complying with the terms of the Church Amendments, the Danforth Amendment, and the Weldon Amendment and assigns the DHHS Office for Civil Rights (also responsible for HIPAA privacy) the task of enforcement.¹⁵⁴ DHHS proposed and adopted the rule after the cutoff date at the end of the presidential term (six months¹⁵⁵) “to ensure that, in the delivery of health care and other health services, recipients of Department funds do not support coercive or discriminatory practices in violation of these laws.”¹⁵⁶ The need for immediate regulatory action is difficult to perceive, as these conscience clause funding statutes have been on the books for years, and DHHS had no evidence that they were actually being violated.¹⁵⁷ Nevertheless, the conscience regulation was adopted on December 18, 2008 and was effective as of Inauguration Day.¹⁵⁸ The conscience regulation has the potential to affect approximately 572,000 healthcare providers, including hospitals, nursing homes, physicians, laboratories, dentists and other allied health professionals (and their training programs) who accept federal funding for one aspect of their reimbursement.¹⁵⁹

Even if the Obama Administration revises or eliminates the conscience regulation,¹⁶⁰ it serves as an example of how far current spending jurisprudence can be stretched. In publishing the regulations, DHHS was aware that its power lay in placing conditions on spending. Twice in responding to comments, DHHS stated that an entity that receives federal funds agrees to accept that those funds may come with certain conditions.¹⁶¹ The first response was to a concern that the definition of healthcare entity is too broadly and generally stated. The second response was more pointed, responding to a concern that state law protecting access to emergency contraception and birth control could conflict with the new conscience regulation. DHHS chided states that they must “ensure that they do not take action that would violate these established federal protections. By accepting federal funds, states accept the conditions that the Congress has imposed on the receipt of those funds.”¹⁶² The regulation is so broadly worded, however,

¹⁵² Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, Title V, §508.

¹⁵³ 73 Fed. Reg. 78072 (Dec. 19, 2008).

¹⁵⁴ *Id.* at 78074.

¹⁵⁵ *Id.* at 78089. A commenter noted that the White House had issued a directive that all new regulations be submitted by June 1, 2008 “except in ‘extraordinary circumstances.’” *Id.* DHHS rejected the commenter’s suggestion that the agency must explain the extraordinary circumstances or withdraw the rule, stating that the internal memorandum gave no one authority to challenge the timing of the DHHS rule. *Id.* While technically correct, the timing remains suspect.

¹⁵⁶ *Id.* at 78072.

¹⁵⁷ *Id.* at 78083 (commenters suggested that DHHS should conduct a study to determine whether conscience clause statutes were actually being violated, but DHHS rejected this request as unnecessary).

¹⁵⁸ Some believe that the Obama administration will immediately suspend this regulation. *See, .e.g.,* Laura Meckler, *Bush-Era Abortion Rules Face Possible Reversal*, WALL ST. J., Dec. 17, 2008.

¹⁵⁹ 73 Fed. Reg. at 78094.

¹⁶⁰ 74 Fed. Reg. 10207 (Mar. 10, 2009).

¹⁶¹ *Id.* at 78076, 78088.

¹⁶² 73 Fed. Reg. at 78088.

that it could protect those who are opposed to use of contraception, a concept that extends beyond the reach of *McRae* and *Maher*.

In fact, DHHS declined to alter the wording of the regulation so that the term “abortion” does not include contraception, averring

such questions over the nature of abortion and the ending of a life are highly controversial and strongly debated. [DHHS] believes it can enforce the federal health care conscience protection laws without an abortion definition just as [it] has enforced the Hyde Amendment ... without a formal definition. Additionally, nothing in this rule alters the obligation of federal Title X programs to deliver contraceptive service to clients in need as authorized by law and regulation.¹⁶³

In other words, DHHS was aware that this regulation protects those who assert that contraception is the same thing as abortion (which is scientifically incorrect) when they refuse to prescribe or dispense contraception or emergency contraception.

DHHS also rejected the argument that this regulation could have a disparate impact on poor women, who rely on federally funded programs to access healthcare services and prescriptions.¹⁶⁴ A number of commenters expressed concern that “low-income patients, minorities, the uninsured, patients in rural areas, the Medicaid population, [and] other medically underserved populations” would suffer under the conscience regulation’s requirements.¹⁶⁵ The DHHS response was a combination of platitudes and side-stepping. First DHHS noted that many Americans have problems accessing healthcare and listed a number of unrelated initiatives designed to facilitate medical care for different populations. Then the agency stated support for new programs that will increase access to healthcare for all. Finally, DHHS disagreed that already disadvantaged populations would be harmed by the new regulation, focusing instead on the needs of religious healthcare providers and their objections to certain reproductive health services and rejecting the idea that failure to protect contraceptive access in the regulation would actually result in diminished access for vulnerable populations.¹⁶⁶

The conscience regulation created a certification requirement that also poses a new conditional spending problem.¹⁶⁷ Certification requirements have been successfully used to prosecute civil False Claims Act¹⁶⁸ cases, which opens the door to more whistleblower actions.¹⁶⁹ The theory is known as a “tainted claim” -- even if the healthcare provider has actually performed the medical care as claimed, if the provider is violating a law that is key to the government’s decision regarding reimbursement, then the claim can still be deemed false under the terms of the civil False Claims Act.¹⁷⁰ This possibility extends beyond the intended reach of the conscience clause funding statutes, but DHHS expressed no substantive response to the concern that a new avenue of False Claims Act cases could arise.¹⁷¹

¹⁶³ *Id.* at 78077.

¹⁶⁴ *See* notes ___ and accompanying text, *infra*.

¹⁶⁵ *Id.* at 78080.

¹⁶⁶ *Id.* at 78080-81.

¹⁶⁷ 73 Fed. Reg. at 78098, codified as 45 C.F.R. § 88.5.

¹⁶⁸ 31 U.S.C. §§ 3729-3731.

¹⁶⁹ 31 U.S.C. § 3730.

¹⁷⁰ *See generally* United States *ex rel.* Mikes v. Strauss, 274 F.3d 687 (2d Cir. 2001) (delineating and adopting the theories of express false certification, implied false certification, and worthless services).

¹⁷¹ *See* 73 Fed. Reg. at 78079 (responding that the agency does not consider the certification to be a “material prerequisite” to payment; this will not stop whistleblowers from filing qui tam actions under 31 U.S.C. §3731). For a discussion of the harmful consequences of broadly accepted whistleblower-created causes of action under the False Claims Act, *see* Dayna Bowen Matthew, *The Moral Hazard Problem with Privatization of Public*

The conscience regulation is problematic for at least three reasons. First, it significantly expands the laws upon which it builds. Though the Danforth Amendment and the Weldon Amendment permit refusal to participate in abortion for religious or general moral motivation, abortion and sterilization were the original targets of these Amendments. DHHS drafted the conscience regulation so that it permits healthcare providers to reject other reproductive health services, such as contraception, with the imprimatur of the federal government, and for reasons that are not protected by the First Amendment. This raises concerns about the agency overstepping its legislative mandate, an issue that was briefed by the states that are now challenging the conscience regulation in federal court.¹⁷²

Second, federal funding is being wielded in two distinct yet overlapping ways that aggrandize the congressional power to spend. The pure funding statutes prohibit key programs such as Medicaid and SCHIP from paying for most abortions, while the conscience clause funding statutes encourage healthcare providers to turn women away with no obligation to provide an alternative.¹⁷³ Even if Medicaid paid for abortions, poor women would still face the difficulty of providers being excused from performing certain medical services. Conversely, as was acknowledged in *Singleton v. Wulff*, when Medicaid does not pay, it is harder for a poor woman to find a healthcare provider who will help her understand and pursue her medical options because of the conscience clause funding statutes and the conscience regulations. By the mechanism of conditions on spending, the federal government is working around *Roe* and *Casey* (and maybe even *South Dakota v. Dole*, discussed below).

Third, this regulation distends the *McRae* and *Maher* precedents by placing the conscience-exercising healthcare provider’s rights above the woman’s rights, even if the woman is not subject to the conditions attendant to Medicaid enrollment. In other words, an obstacle exists in the path of *all* who seek to exercise their rights to not only abortion and sterilization but contraceptive use as well. Even if one accepts the flawed precedents of *McRae* and *Maher*, those cases applied just to federal programs that provide medical assistance to poor Americans. The conscience clause funding statutes and conscience regulation use the federal spending power to narrow access to reproductive care for all women, even in private payment situations, because the laws affect all healthcare providers who accept any form of federal reimbursement. This interpretation of the state’s interest and reach of conditional spending may be unprecedented. It emphasizes how conditions on federal funds can affect not only individuals who are the ultimate beneficiaries of the conditional funds but also those who are not.

IV. Reconnecting Spending Clause Jurisprudence

Enforcement: The Case of Pharmaceutical Fraud, 40 U. MICH. J.L. REFORM 281 (2007) (describing the over-litigation that has occurred under the federal False Claims Act as a result of whistleblowers, particularly with regard to the pharmaceutical industry).

¹⁷² Connecticut, California, Illinois, Massachusetts, New Jersey, Oregon, and Rhode Island filed a lawsuit against DHHS in mid January. David Goodhue, *States, Groups File Suit to Stop Rule Protecting Doctors Who Refuse to Perform Abortions*, ALL HEADLINE NEWS, Jan. 19, 2009, available at <http://www.allheadlinenews.com/articles/7013760235> (last visited Jan. 23, 2009). In addition, New York is suing DHHS, as are the Planned Parenthood Federation of America, the National Family Planning and Reproductive Health Association, and the American Civil Liberties Union. See John Gever, *States File Suit to Overturn Healthcare Worker ‘Conscience Rule’*, MEDPAGE TODAY, Jan. 19, 2009, available at <http://www.medpagetoday.com/PublicHealthPolicy/12507>.

¹⁷³ See *id.* at 78089 (commenter recommended that DHHS create a process for providers to refer patients to other medical professionals who did not object, but DHHS refused to include such a requirement in the rule).

In the current political climate, changes seem more likely to occur through Congress altering the legacy of *Maier* and *McRae* through legislative action than through the Court revisiting its long-stable precedents. This section will suggest that either Congress or the Court could effectuate divergence from the current constitutionally questionable path.

A. Legislative Constitutionalism

Congress was responsible for creating the conditions that lead to the benchmark *Maier* and *McRae* decisions, and it can remove those conditions as it continues to restructure federal healthcare programs. Though the Court has given Congress the authority to place conditions such as the Hyde Amendment on federal spending, Congress need not follow the Court’s lead. In other words, Congress could cease creating pure funding statutes and conscience clause funding statutes, or at least modify the most broadly worded existing laws, so that the individual is not negotiated out of the federal-state relationship. The pure funding statutes are easily changed, as they are often riders to appropriations bills. The conscience clause funding statutes are a bit more complex, as they are not appropriations riders. Nevertheless, the current political balance, in addition to the conservative nature of the Roberts Court, indicates that legislative action could be the more likely remedy.

A model exists for Congress to consider the impact of federal programs such as Medicaid on women. The American College of Obstetricians and Gynecologists (ACOG) has issued a series of healthcare reform proposals entitled “Health Care for Women Health Care for All” that describe in some detail the kind of medical coverage that all women should be able to receive at all stages of life.¹⁷⁴ ACOG describes that all women should have insurance coverage for “1) Primary and preventive services, including family planning; 2) Pregnancy-related and infant care; 3) Medically and surgically necessary and appropriate services in all health care settings, including outpatient, hospital, nursing facility, hospice, and at-home care; 4) Prescription drugs, and 5) Catastrophic care.”¹⁷⁵ ACOG’s intent is to describe minimal basic care for all women, regardless of private or public coverage, and it describes exactly the kinds of care that all women should receive at each stage of life. This assessment includes, for instance, preventive care medical evaluations that include family planning beginning at age thirteen; pregnancy-related care that includes “abortion services, including medical abortion” and sterilization; “medically and surgically necessary and appropriate services” that include abortion and sterilization; and prescription drugs that include contraceptives.¹⁷⁶

The ACOG healthcare reform proposal has received congressional attention recently. On February 11, 2009, Representative Schakowsky and Senator Stabenow presented resolutions in the House and Senate encouraging adoption of the ACOG plan.¹⁷⁷ The concurrent resolutions contain the same language and express the “sense of Congress that national health care reform should ensure that the health care needs of women and of all individuals in the United States are met.”¹⁷⁸ Though the concurrent resolutions are merely hortatory, they are meaningful at a time

¹⁷⁴ American College of Obstetricians and Gynecologists, *Covering Specific Services in Women’s Health, Health Care for Women Health Care for All: A Reform Agenda* (2008), <http://www.acog.org/departments/govtrel/HCFWHCFA-SpecificServices.pdf>.

¹⁷⁵ *See id.* at 1.

¹⁷⁶ *See id.* at 1-4.

¹⁷⁷ S. Con. Res. 6 (Feb. 11, 2009); H. Con. Res. 48 (Feb. 11, 2009).

¹⁷⁸ *See id.*

that healthcare reform is front and center on the national stage and seem particularly important for the pure funding statutes.

Admittedly, it seems unlikely that the conscience clause spending statutes will be greatly modified by Congress, even though the conscience regulation is being revisited by the Obama administration. The key would be for Congress to attempt a balance in the conscience regulations, and not just the kind of balance that the Church Amendments have wherein the healthcare provider cannot be penalized for participating in or refusing to participate in abortion or sterilization services. Though the Church Amendments are more balanced than the Weldon and Danforth Amendments, they still fail to protect the individual impacted by the conditions on spending. A requirement for referrals would go a long way toward balancing what some see as competing fundamental rights.¹⁷⁹

Congress’s refusal to perpetuate the Hyde-type legislative language would go a long way toward erasing the peculiar legacy of *Maier* and *McRae*. Even so, the conditional spending power that facilitated the Hyde Amendment would remain, so the Court’s interpretation of conditions on federal spending is worth a revisit.

B. Judicial Constitutionalism

Compared to other Congressional powers, the Spending Clause has been interpreted relatively infrequently. Though the Court determined in 1936 that the spending power was a stand-alone enumerated congressional power,¹⁸⁰ the Court did not delineate the test for evaluating when conditions placed on federal funds will be deemed constitutional until 1987 in *South Dakota v. Dole*.¹⁸¹ South Dakota challenged a minimum drinking age requirement attached to federal highway funding, claiming the condition was unconstitutional. Chief Justice Rehnquist rejected this argument by setting forth and applying what is now the five part test for determining the constitutionality of conditions on federal spending.¹⁸² The *Dole* decision focused on the federal-state relationship and essentially allowed the federal government to regulate states indirectly through conditional spending in ways that it might not be able to do directly.¹⁸³ This narrow focus on the federal-state relationship is challenging because programs like Medicaid and SCHIP are not just programs that command state compliance with federal law, they are also programs intended to benefit particular individuals by creating a federal scheme that is to be followed and administered by the states. Though the most coherent expression of the limits of federal conditional spending, the *Dole* test fails to account for the beneficiary of the federal scheme.

1. (Re)Applying the Dole Test – General Welfare

The first element of the *Dole* test demands that the federal government spend only for the “general welfare,” which originates from the language of Article I.¹⁸⁴ Chief Justice Rehnquist wrote that courts should defer to the judgment of Congress rather than second guess whether

¹⁷⁹ See, e.g., Wilson, *supra* note 150, proposing that such a balance can be achieved at the state level.

¹⁸⁰ *United States v. Butler*, 297 U.S. 1 (1936).

¹⁸¹ *South Dakota v. Dole*, 483 U.S. 203 (1987).

¹⁸² See *id.* at 207-08.

¹⁸³ See Lynn A. Baker, *Conditional Federal Spending after Lopez*, 95 COLUM. L. REV. 1911, 1914 (1995).

¹⁸⁴ The Spending Clause provides: “Congress shall have Power ...to pay the Debts and provide for the common Defence and general Welfare of the United States....” Art. I, Sec. 8, Cl. 1.

spending is actually for the general welfare.¹⁸⁵ As a whole, the Medicaid Act can be described as providing for the general welfare. Congress has decided to provide healthcare services to people who would not otherwise be able to access them due to low income status (albeit not all such people).¹⁸⁶ But part of the inquiry should be which aspect of the spending program is at issue in determining spending for the general welfare: is it Medicaid as a whole program, or is it the limits placed on use of Medicaid funds by the Hyde Amendment? This is as tricky as framing questions of injury for standing, because the characterization determines the outcome. If the spending activity is narrowed to placing limits on use of federal funds to prevent paying for abortion, the benefit for the general welfare is muddied; forcing poor women to birth children, or to forgo life necessities to seek a safe abortion, do not appear to be outcomes that serve the general welfare. Nevertheless, the Court has essentially rendered this element of the *Dole* test a political question, and scholarly observers consider the general welfare requirement to be so much surplusage.¹⁸⁷ The remaining four elements of the *Dole* test are not all actively enforced, but neither are they considered to be political questions.

2. Clear Conditions

The *Dole* test next asks whether the federal government has provided unambiguous notice of conditions on spending, a standard that was narrowed by the 2006 Roberts Court decision in *Arlington Central School District Board of Education v. Murphy*, which demands “clear” notice.¹⁸⁸ According *Arlington*, this means the Court must ask whether a “state official who is engaged in the process of deciding whether the State should accept ... funds and the obligations that go with those funds... would clearly understand ... the obligations of the Act In other words, we must ask whether the [act] furnishes clear notice....”¹⁸⁹

As an example for the pure funding statute model, consider the Medicaid Act, a forty-plus year old law that Congress has modified yearly if not more frequently.¹⁹⁰ It is difficult to analyze whether the Medicaid Act provides state officials with clear notice given the ever-changing nature of the program and the long-term state reliance on Medicaid funding.¹⁹¹ The Hyde Amendment would seem to defy the notion that a constantly amended statutory scheme cannot be clear, however it is also technically not a part of the Medicaid Act, it is part of the yearly appropriations bill that facilitates the ongoing funding of the Medicaid program. This pure funding statute does not contain the limitation on abortion services; instead, the condition on spending is placed on DHHS, which passes the condition on to the states, most of which then

¹⁸⁵ *Dole*, 483 U.S. at 207. The Eighth Circuit’s decision below added additional clarification that was not adopted by Rehnquist’s majority opinion (which otherwise tracks the appellate court’s decision in many ways). That court noted general welfare means “the well-being of the nation as a whole” rather than a “particular region or locality.” *State of South Dakota v. Dole*, 791 F.2d 628, 631 (8th Cir. 1986).

¹⁸⁶ 42 U.S.C. § 1396.

¹⁸⁷ See, e.g., Lynn A. Baker & Mitchell N. Berman, *Getting off the Dole: Why the Court Should Abandon Its Spending Doctrine, and How a Too-Clever Congress Could Provoke It to Do So*, 78 IND. L.J. 459, 464-65 (2001) (describing the general welfare prong as a “complete throwaway”).

¹⁸⁸ *South Dakota v. Dole*, 483 U.S. at 207; *Arlington Central Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006).

¹⁸⁹ 548 U.S. at 296.

¹⁹⁰ 42 U.S.C. §§ 1396-1396v (2006).

¹⁹¹ See Nicole Huberfeld, *Clear Notice for Conditions on Spending, Unclear Implications for States in Federal Healthcare Programs*, 86 N.C. L. REV. 441, 488 (2008) (describing the changing nature of programs like Medicare and Medicaid and questioning the utility of clear statement rules for such long-standing programs).

choose to pass the limitation on to Medicaid enrollees. Acknowledging this technical linkage, the Hyde Amendment and other pure funding statutes require that no funds may be used for abortion except to save the life of the mother, or sometimes in instances of rape or incest. For purposes of the *Dole* test, this does not appear to be ambiguous language.

The *Dole* analysis ends there, which is at least part of the conundrum. The state accepts certain federal conditions knowing that they are (or may be) unconstitutional as a quid pro quo for much needed federal funds.¹⁹² The stance of the Court has long been that the federal government may do indirectly through spending what it may not do directly through other Article I powers.¹⁹³ But the clear notice prong of the *Dole* test only asks if the state understands the conditions of spending and does not question the constitutionality of the condition or the impact on spending beneficiaries. The fourth *Dole* prong, unconstitutional conditions, focuses on the party directly affected by the spending. But if the state and the federal government are complicit in violating a constitutional right by means of conditional spending, it is nonsensical to simply confirm that the condition is “clear.”¹⁹⁴

Stated differently, the exercise of this particular right is much like the Sixth Amendment right to assistance of counsel,¹⁹⁵ in that it requires the assistance of a professional, a physician. Denial of payment to the healthcare provider is denial of the right itself, whether or not the condition of that funding is clear to the state accepting the federal funds.¹⁹⁶ Both the healthcare provider and the Medicaid enrollee are affected by the state’s decision to accept the condition of spending but unaccounted for in the clear statement rule. Jurists such as Justice Scalia who believe that third party beneficiaries of federal spending have no right to sue to enforce benefits may also be likely to assert that the impact on the individual is an unnecessary inquiry.¹⁹⁷ That response would be misleading, though, as conditional spending affects not just the state but also the individual who ultimately receives the benefit of the federal spending. One counter-argument might then be that the federal government could choose not to spend, leaving the beneficiary in a worse situation (the greater includes the lesser position). Perhaps, but in the instance of both pure funding statutes and conscience clause funding statutes, the federal

¹⁹² States will readily admit that rejecting federal Medicaid funds because of questionable conditions attached to the spending is not an option. For an unsuccessful attempt at arguing this amounts to coercion by the federal government, see *West Virginia v. United States Dept. of Health and Human Svcs.*, 289 F.3d. 281 (4th Cir. 2002).

¹⁹³ *South Dakota v. Dole*, 483 U.S. at 207. Justice Rehnquist wrote: “objectives not thought to be within Article I’s ‘enumerated legislative fields,’ may nevertheless be attained through the use of the spending power and the conditional grant of federal funds.” *Id.*

¹⁹⁴ See Laurence H. Tribe, *The Abortion Funding Conundrum: Inalienable Rights, Affirmative Duties, and the Dilemma of Dependence*, 99 HARV. L. REV. 330, 333 (1985) (“failure to provide the needed aid at public expense amounts to forced alienation of the underlying right.”)

¹⁹⁵ *Gideon v. Wainwright*, 372 U.S. 335 (1963) (fundamental right to appointment of counsel in serious criminal cases); *Alabama v. Shelton*, 534 U.S. 654 (2002) (fundamental right to appointment of counsel in misdemeanor case where defendant sentenced to a suspended period of incarceration).

¹⁹⁶ See Kenneth Agran, *When Government Must Pay: Compensating Rights and the Constitution*, 22 CONST. COMMENTARY 97, 101-02 (2005) (describing a line of decisions requiring the government to pay to facilitate “equal access” for indigent citizens including civil and criminal litigation).

¹⁹⁷ Certain justices believe that beneficiaries of federal spending should not be able to sue to enforce rights to their benefits through 42 U.S.C. § 1983 because third party beneficiaries could not sue at the time section 1983 was passed, perhaps revealing a larger attitude regarding legal entitlements and the individuals who benefit from such programs. See Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid*, 42 U.C. DAVIS L. REV. 413 (2008).

government already has chosen to spend and is using that decision to manipulate providers and beneficiaries of federal healthcare programs.

The clear notice question is complicated further by the conscience clause funding statutes. The *Dole* test demands that a state have clear notice, but again, states are not the only parties that accept federal funds. A hospital, for example, chooses to accept federal funds when it participates in Medicaid and accepts the conditions that come with Medicaid funds. One of those conditions is now the conscience regulation, which demands that the hospital, as an entity that accepts federal funding, certify compliance with the conscience clause funding statutes and the conscience regulation. The clear notice requirement of the *Dole* test does not protect the hospital, as it focuses on a state’s acceptance of clear conditions on federal funds, and it does not protect individuals who seek treatment in the hospital and have no control over the conditions on federal spending that may affect their care path.¹⁹⁸

3. Reasonably Related

The third *Dole* requirement is that “conditions on federal grants might be illegitimate if they are unrelated ‘to the federal interest in particular national projects or programs.’”¹⁹⁹ The Rehnquist majority did not consider the “germaneness” element a serious concern for South Dakota and therefore did not elaborate on its boundaries, but Justice O’Connor’s brief dissent gave this prong some teeth.²⁰⁰ Justice O’Connor wrote:

There is a clear place at which the Court can draw the line between permissible and impermissible conditions on federal grants. “Congress has the power to spend for the general welfare, it has the power to legislate only for delegated purposes.... The appropriate inquiry, then, is whether the spending requirement or prohibition is a condition on a grant or whether it is regulation.”²⁰¹

Justice O’Connor’s distinction draws on the notion from *Butler* that the power to spend is not limited to supporting the enumerated powers of Congress in Article I, but it also does not empower Congress to regulate in ways that otherwise would be prohibited.²⁰² This analysis would then ask whether Congress can prohibit poor women from accessing abortion as a condition of Medicaid enrollment (which Representative Hyde stated was the intent of the Hyde Amendment); the answer would be no.

This does not capture the whole predicament, though, as some of the pure funding statutes are worded so as to directly address the way in which funds should be spent, also part of

¹⁹⁸ The conscience regulation may create a conflict with another federal law, the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires all hospitals that accept Medicare as reimbursement and that have emergency departments to screen and treat or properly transfer all patients that present in the emergency department. See 42 U.S.C. § 1395dd. If a woman is raped and presents in the emergency department, the hospital has an obligation to treat her, for which the standard treatment may include providing her with the morning after pill (a drug that prevents conception, it is not an abortifascent). If a healthcare provider working in the emergency department refuses to provide the morning after pill (and will not refer the patient to another healthcare professional who is willing to supply the drug), then the hospital would be violating its duties under EMTALA and would potentially be civilly liable to the patient and to the federal government for violations of that statute. Though this issue was raised by a commenter to the conscience regulation, DHHS dismissed it summarily. See 73 Fed. Reg. at 78087.

¹⁹⁹ 483 U.S. at 207.

²⁰⁰ See *id.* at 213-14 (O’Connor, J., dissenting).

²⁰¹ *Id.* at 215-16.

²⁰² See *id.* at 216.

Justice O’Connor’s dissent in *Dole*. Thus, germaneness must be about more than simply how funds should be spent. For example, the Hyde Amendment is not germane for a second reason. The federal government spends Medicaid dollars to enable “each State... to furnish medical assistance on behalf of families with dependent children ... whose income and resources are insufficient to meet the costs of necessary medical services.”²⁰³ Thus, the Medicaid Act facilitates provision of medical care to the indigent, but the Hyde Amendment deliberately withholds care to the indigent. The national statistics are well known; half of all pregnancies in the United States are unintended; a third of all women of childbearing age will terminate pregnancy; more than a fifth of all women will have an abortion by the end of their reproductive years.²⁰⁴ Abortion is one of the most commonly performed medical procedures in the United States, and it requires the assistance of a medical professional to safely perform the procedure either by medication or surgery. Pure funding statutes such as the Hyde Amendment fail the germaneness test by denying to women non-experimental, medically necessary assistance, a direct conflict with the goal of the Medicaid Act.²⁰⁵ The privacy right protected by *Roe*, *Casey*, and (perhaps) *Gonzales v. Carhart* need not be raised to come to this conclusion. Quite simply, refusal to fund a common, necessary medical procedure for a certain portion of the population is not rationally related to funding medical assistance for that portion of the population.²⁰⁶

The reasonable relationship is even more attenuated with the conscience clause funding statutes. The *Dole* majority held that “Congress conditioned the receipt of federal funds in a way reasonably calculated to address this particular impediment to a purpose for which the funds are expended,” a relatively easy level of review to pass.²⁰⁷ Yet, this standard for analysis is flawed when considering the conscience clause spending statutes and the conscience regulation. For example, the Danforth Amendment is attached to the Public Health Services Act, an act that is intended to facilitate creation of “family planning facilities.”²⁰⁸ It stretches the bounds of reason to consider the condition to that act allowing healthcare providers to opt out of abortion, sterilization, and contraception to be a condition that is “reasonably calculated” to furthering the congressional goal of providing family planning. But this is what the conscience clause funding statutes (and regulation) do; they attach conditions to spending that are anathema to the goal of the spending itself.

Further, the conscience clause funding statutes attach conditions in such a way that individuals who are not beneficiaries of federal spending are also subject to their limitations. All patients in a hospital, regardless of whether they rely on public or private insurance mechanisms,

²⁰³ 42 U.S.C. § 1396 (2006).

²⁰⁴ See Guttmacher Institute, *Facts on Induced Abortion in America* (2008), http://www.guttmacher.org/pubs/fb_induced_abortion.html.

²⁰⁵ If the goal is to treat as many as possible with minimal federal funds through Medicaid, the Hyde Amendment achieves the opposite result, as abortion is much cheaper than pregnancy and child care. A number of legislators raised this point during the extensive debates over the Hyde Amendment when it was first passed, but Representative Hyde and other anti-abortion legislators likened this argument to Nazi eugenic policies. See CONG. REC., House, 19698, 19703-04 (June 17, 1977). They failed to support the programs necessary to support women and children once the pregnancy came to term, a concern also raised by legislators during the debates. See *id.* at 19708-09.

²⁰⁶ Amicus briefs urged the Court in *Dole* to “establish that a condition on federal funds is legitimate only if it relates directly to the purpose of the expenditure to which it is attached” but the Court declined, reasoning that the petitioners had not requested such an interpretation and that the issues in the case did not require such restrictive language. *Dole*, 483 U.S. at 209, n.3.

²⁰⁷ 483 U.S. at 209.

²⁰⁸ 42 U.S.C. § 300 (2006).

are subject to the rules that protect healthcare providers who refuse to participate in abortion or sterilization. The conscience regulation expands the condition by protecting those with moral objections, not just religious objections, and by allowing everyone in the hospital to refuse to participate, including those who have no direct patient contact. The technician who sterilizes instruments could refuse to participate in reproductive health services, as could the janitor, the receptionist, and any other person working in the hospital. Each of these actors has the potential to disrupt the work of the hospital, and the treatment of all patients, regardless of the insurance source. The Court’s failure to apply germaneness has facilitated this tenuous connection between the condition and the federal funding.²⁰⁹

4. *Unconstitutional Conditions*

The fourth prong of the *Dole* test states that “other constitutional provisions may provide an independent bar to the conditional grant of federal funds.”²¹⁰ Chief Justice Rehnquist clarified this element by stating that the spending power cannot be used “to induce the States to engage in activities that would themselves be unconstitutional.”²¹¹ The majority used the example that the federal government could not condition receipt of federal funds on the state inflicting cruel and unusual punishment or on the state engaging in violations of the Equal Protection Clause.²¹² The Court found that the Twenty-first Amendment did not pose an independent constitutional bar to the condition on highway funding. The majority simply held that the state was induced to enact a higher drinking age than it might have otherwise, which did not violate the reservation of power to the states in either the Twenty-first or the Tenth Amendments.²¹³ The Court’s articulation of the fourth prong does not necessarily lead to this result, but the unconstitutional conditions doctrine is unpredictable. Indeed, many scholars have observed that the Court applies the doctrine of unconstitutional conditions unevenly, and the outcome seemingly depends on the right at stake rather than a consistent application of the law.²¹⁴

The *Dole* straightforward description of the independent constitutional bar would seem to reverse *McRae* and *Maher*, as they permitted the federal government to impose conditions on federal funds that require the state to either pay for reproductive services without a federal match or require that women who want Medicaid assistance waive their right to access abortion. The former is not necessarily the imposition of an independent constitutional bar, but it does implicate coercion, discussed in the next section. The latter does implicate an independent constitutional bar, but *McRae* and *Maher* have not been overruled, the result of which is the many pure funding statutes and conscience clause funding statutes discussed herein.

²⁰⁹ See Baker & Berman, *supra* note 187, at 465-66.

²¹⁰ 483 U.S. at 208.

²¹¹ *Id.* at 210.

²¹² See *id.* at 210-11.

²¹³ 483 U.S. at 211-12.

²¹⁴ A number of legal academic luminaries have attempted to make sense of the unconstitutional conditions doctrine, which Professor Farber recently called a “doctrinal swamp.” See Daniel Farber, *Another View of the Quagmire: Unconstitutional Conditions and Contract Theory*, 33 FL. ST. U. L. REV. 913, 914 (2006); see also Mitchell N. Berman, *Coercion Without Baselines: Unconstitutional Conditions in Three Dimensions*, 90 GEO. L.J. 1 (2001); Kathleen M. Sullivan, *Unconstitutional Conditions*, 102 HARV. L. REV. 1413 (1989); Richard A. Epstein, *The Supreme Court, 1987 Term Foreword: Unconstitutional Conditions, State Power, and the Limits of Consent*, 102 HARV. L. REV. 4 (1988); Seth F. Kreimer, *Allocational Sanctions: The Problem of Negative Rights in a Positive State*, 132 U. PA. L. REV. 1293 (1984).

The *Dole* read of the unconstitutional conditions doctrine focuses solely on the relationship between the federal government, the condition, and the state. As this article has established, that standard analysis does not account for all parties to the transaction. Admittedly, the Court has chipped away at the *Roe* precedent in such a way that its analysis has been twisted into a different kind of fundamental right.²¹⁵ Nevertheless, the precedents still stand, and yet Congress has bypassed them by paying for medical assistance in every other situation in which medical care is necessary, including childbirth, except this one.

5. Compulsion

The *Dole* test contains a fifth element, which states that at some point congressional coercion becomes impermissible compulsion.²¹⁶ The Court’s brief analysis indicated that this prong is, at least in part, about the amount of money at stake. In *Dole*, states would lose five percent of the offered federal highway funds if they refused to comply with the drinking age condition; the Court did not deem this potential loss of funds to be “compulsion.”²¹⁷ This is another element of the *Dole* test that has been little-interpreted and, as a result, few lower federal courts have been willing to apply the compulsion prong (often referred to as “coercion”).²¹⁸

Even so, the *Dole* Court appeared to find relevant the amount of federal funding provided and jeopardized for non-compliance; in that vein, consider the monetary aspect of the pure funding statutes. States rely very heavily on Medicaid funding, which promises a federal match (known as the “FMAP”) ranging from 50% to 83%.²¹⁹ The more a state chooses to spend on its “deserving poor,” the more the federal government must pay to match that state’s expenditures.²²⁰ Every state has participated in Medicaid since the early 1970s, and many of the poorest states are the richest recipients of federal Medicaid funds.²²¹ For example, Mississippi had the lowest median household income in 2007.²²² The most recent year for which complete data are available shows that in fiscal year 2005, Mississippi’s federal match was 76.3%; the state received \$3.20 for every dollar it spent on Medicaid (yet it still spent only \$4,459 per

²¹⁵ Typically, if the government wants to inhibit the exercise of a fundamental right, it must have a compelling reason for doing so and that reason must be narrowly tailored to the compelling governmental interest. This strict scrutiny test was applied in *Roe*, at least pre-viability. See *Roe v. Wade*, 410 U.S. 113, 155 (1973). In *Casey*, however, the level of scrutiny was lowered to an “undue burden” analysis, a standard that had been at least mentioned in other abortion-related cases but that had not been applied to fundamental rights. See *Casey*, 505 U.S. at 874, 877-78. The undue burden standard appears to have been further eroded by *Gonzales v. Carhart*, in which Justice Kennedy applied a hybrid undue burden/rational basis review to the federal Partial Birth Abortion Ban Act of 2003. See *Gonzales v. Carhart*, 550 U.S. 124, 127 S. Ct. 1610, 1634-35 (2007).

²¹⁶ 483 U.S. at 211. As stated by the majority: “in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which ‘pressure turns into compulsion.’” *Id.*

²¹⁷ 483 U.S. at 211-12.

²¹⁸ See, e.g., *West Virginia v. United States Dept. of Health and Human Svcs.*, 289 F.3d 281 (4th Cir. 2002). For discussion of this case and its elaboration on the compulsion idea, see Huberfeld, *Clear Notice*, *supra* note 191, at 458-62.

²¹⁹ See 42 U.S.C. § 1396d(b) (delineating the formula for the Federal Medical Assistance Percentage, or FMAP, which determines the rate at which the federal government will match state funds).

²²⁰ See 42 U.S.C. § 1396d(b).

²²¹ See STEVENS & STEVENS, *supra* note 19, at 60-61.

²²² United States Census Bureau Press Release, *Household Income Rises, Poverty Rate Unchanged, Number of Uninsured Down* (Aug. 26, 2008), http://www.census.gov/Press-Release/www/releases/archives/income_wealth/012528.html.

enrollee, lower than the national average of \$4,662).²²³ Over half of all births in Mississippi are covered by Medicaid.²²⁴ Compare Mississippi to New York, one of the wealthier states, which has an FMAP of 50%, still spends significantly more per beneficiary (\$7,733), and covers abortion beyond the confines of the Hyde Amendment.²²⁵

Given the degree to which poor states rely on Medicaid funding, it appears that federal compulsion could be present. Though the Hyde Amendment does not directly force states to choose between accepting Medicaid funding and paying for abortion, most states only pay for the limited abortion services that are permitted by the Hyde Amendment. The example of Mississippi and New York illustrates that the states that have chosen to pay for abortions beyond the Hyde Amendment are also states that have a lower FMAP, indicating that they can afford to pay for more medical assistance for their poor. The poorest states tend not to pay for more than Medicaid will cover, but given the statistics regarding who relies the most heavily on Medicaid for pregnancy care and who seeks abortion services, it seems that women in these states also need Medicaid’s assistance the most.²²⁶ It is difficult to say if most states are choosing not to fund beyond the scope of the Hyde Amendment because of funding, ideology, both, or neither; however, before the Hyde Amendment, all states funded abortion under the requirements of the Medicaid Act, and after the Hyde Amendment only seventeen states provide funding beyond its strictures.²²⁷

States have participated in Medicaid for more than forty years, and choosing to reject Medicaid funds based on certain conditions seems improbable, especially knowing that states could not otherwise shoulder the burden of their low-income and chronically-ill patients and that their healthcare systems would likely collapse.²²⁸ Though federal courts have often emphasized that states can refuse Medicaid funds if they dislike the conditions imposed on them,²²⁹ this response is unrealistic; no matter how burdensome the condition, states have not ceased their Medicaid participation.²³⁰ Likewise, poor individuals have the choice of being uninsured, a sure barrier to medical care, or being enrolled in Medicaid (assuming they meet the categorical and financial eligibility requirements). The Court in *McRae* and *Maher* indicated a belief that women could still access those services that the government refused to fund through Medicaid,

²²³ Kaiser Family Foundation State Medicaid Fact Sheets, Mississippi (2009), <http://www.statehealthfacts.org>.

²²⁴ Kaiser Family Foundation Issue Brief, Medicaid’s Role for Women (October 2007), <http://www.kff.org>.

²²⁵ Kaiser Family Foundation State Medicaid Fact Sheets, New York (2009), <http://www.statehealthfacts.org>. See also Guttmacher Institute, *Abortion in Women’s Lives*, Appendix , <http://www.guttmacher.org>.

²²⁶ *Medicaid’s Role for Women*, Kaiser Family Foundation (2007), http://www.kff.org/womenshealth/upload/7213_03.pdf (abortion rates are higher among low-income women and have been increasing since 1994, procedure is becoming increasingly concentrated among poor women, including those on Medicaid).

²²⁷ See notes ___ and accompanying text, *infra*. See also *Abortion in the U.S.: Utilization, Financing, and Access*, Kaiser Family Foundation (2008).

²²⁸ See Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL’Y 5, 6, 27-30 (2006) (explaining that the nation and the states cannot survive without Medicaid but that states also resent the financial burden it represents in their budgets).

²²⁹ See *South Dakota v. Dole*, 483 U.S. at 211-12.

²³⁰ Consider, for instance, the Clawback provision in Medicare Part D, which requires states to pay the federal government for the drug costs faced by dual eligibles (people enrolled in both Medicare and Medicaid). Though this appears to be an impermissible condition on spending and perhaps an impermissible intergovernmental tax, no state has dropped their Medicaid state plan. See Huberfeld, *Clear Notice*, *supra* note 191, at 486-91 (discussing the constitutionality of the Clawback provision).

but it is an illusion of choice given that Medicaid beneficiaries are extraordinarily poor and rely on Medicaid for all of their medical assistance. Justice Blackmun recognized this fact in *Singleton v. Wulff*²³¹ and Justice Brennan so noted in his dissent in *Maher*, and it is as true today as it was thirty years ago.²³² Such realities make the idea of coercion more concrete.

The conscience clause funding statutes further the possibility held within the idea of coercion. These statutes are tied to federal funding but primarily for privately-run healthcare programs, not state programs, and they help to highlight the missing piece in conditional spending. For example, Title X grant recipients create and maintain family planning clinics.²³³ They tend to be local government actors and are more often nonprofit organizations. The Danforth Amendment prevents them from counseling abortion as a form of family planning, and this restriction must be accepted to continue to receive Title X funding. Once an entity has accepted Title X funding, it would be extremely difficult to forgo that funding without shutting down. The Court’s coercion analysis involves the state, an actor that has more bargaining power with the federal government than most others have. The assumption that the party accepting the conditions on spending can simply choose to reject the conditions seems particularly erroneous when the power imbalance between community nonprofit and federal government is considered.

Applied with teeth, the *Dole* test reveals that both the pure funding statutes and the conscience clause funding statutes are impermissible exercises of the federal power to spend. The Court has read the power to spend broadly, but it has created a test that facilitates stronger scrutiny. Given that the Roberts Court has been willing to revisit precedent but has taken incremental steps in the area of the Spending Clause, perhaps the *Dole* test is worth another look.²³⁴

C. Conditions and the Individual – Finding a Framework

The Rehnquist Court was interested in limiting congressional power, yet paradoxically the Court avoided narrowing its interpretation of the Spending Clause, thereby allowing Congress to circumvent constitutional rules by imposing conditions on spending.²³⁵ This leniency seems inconsistent with the Rehnquist Court’s revitalization of federalism and

²³¹ *Singleton v. Wulff*, 428 U.S. at 117 (“A woman cannot safely secure an abortion without the aid of a physician, and an impecunious woman cannot easily secure an abortion without the physician’s being paid by the State.”).

²³² *Maher v. Roe*, 432 U.S. at 454 (Brennan, J., dissenting). Justice Brennan wrote:

The Court’s construction can only result as a practical matter in forcing penniless pregnant women to have children they would not have borne if the State had not weighted the scales to make their choice to have abortions substantially more onerous. Indeed, as the Court said only last Term: “For a doctor who cannot afford to work for nothing, and a woman who cannot afford to pay him, the State’s refusal to fund an abortion is as effective an ‘interdiction’ of it as would ever be necessary.”

Id. citing *Singleton v. Wulff*, 428 U.S. 106, 118-19, n.7.

²³³ 42 U.S.C. § 300.

²³⁴ See Samuel R. Bagenstos, *Spending Clause Litigation in the Roberts Court*, 58 DUKE L. J. 345 (2008); see generally Baker & Berman, *supra* note 187 (arguing that although the *Dole* test has been “toothless” it should not be completely abandoned).

²³⁵ See generally Lynn A. Baker, *Conditional Federal Spending after Lopez*, 95 COLUM. L. REV. 1911 (1995) (explaining how the Commerce Clause jurisprudence of the Rehnquist Court could co-exist with the Spending Clause jurisprudence of the Court).

limitations on Commerce Clause power,²³⁶ though it is consistent with the greater includes the lesser theory of conditional spending.²³⁷ Court watchers predicted that the Spending Clause would be the next front in the federalism revolution, but if that was Chief Justice Rehnquist’s intent, it was unfinished business.²³⁸

In reality, the Court has not addressed the contours of congressional power under the Spending Clause often. With limited jurisprudence to mine, determining the boundaries of the power to spend and to place conditions on the receipt of funds becomes a bit of an exercise in clairvoyance. Nevertheless, given the Roberts Court’s pattern of revisiting precedent, and the fact that the Court has slightly modified the standards for conditions on spending, this section will endeavor to determine how impact on individuals can be reflected better in the conditional spending analysis. The Roberts Court thus far has limited individual rights and read statutory language narrowly, admittedly a tricky combination for contemplating how conditions on spending can be evaluated with an eye toward protecting individuals.²³⁹

Tension exists between *Dole*’s focus on the federal-state relationship and the reality that federal conditions on spending impact more than just the states. Individuals too are subjected to conditions on spending, which was not directly at issue in *Dole*.²⁴⁰ The only canon that appears to cover the federal government–individual relationship is the unconstitutional conditions doctrine, which is incoherent.²⁴¹ This doctrine represents the Court’s analysis of the federal government’s ability to influence individual behavior through “spending, licensing, and employment.”²⁴² In other words, “government may not condition the receipt of its benefits upon the nonassertion of constitutional rights even if receipt of such benefits is ... a ‘mere privilege’....”²⁴³ The doctrine has been applied inconsistently, sometimes protecting fundamental rights and individual liberties, and sometimes not, though the basic idea is that an individual can litigate governmental action that “indirectly inhibits or penalizes the exercise of constitutional rights.”²⁴⁴ Serious scholarly attempts to reconcile the inconsistencies in unconstitutional conditions doctrine have been made, but none has dominated the discourse and the Court continues to be unpredictable in application of the doctrine.²⁴⁵

²³⁶ See *South Dakota v. Dole*, 483 U.S. 203 (1987); *New York v. United States*, 505 U.S. 144 (1992); *Lopez v. United States*, 514 U.S. 549 (1995); *Printz v. United States*, 521 U.S. 898 (1997); *United States v. Morrison*, 529 U.S. 598 (2000).

²³⁷ See *Baker*, *supra* note 183, at 1915, n.13.

²³⁸ See David Freeman Engstrom, *Drawing Lines Between Chevron and Pennhurst: A Functional Analysis of the Spending Power, Federalism, and the Administrative State*, 82 TEX. L. REV. 1197, 1198-99 (2004) (expansive Spending Clause power was minimally impacted by Rehnquist Court’s federalism revolution).

²³⁹ See Erwin Chemerinsky, *Turning Sharply to the Right*, 10 GREEN BAG 2d 423 (2007). Professor Chemerinsky observed: “What does it mean that the Court was more conservative? ... The Court moved significantly to the right on key issues that divide liberals and conservatives - in particular, abortion and race. The Court tended to favor the government over individuals across a wide range of issues. And the Court tended to favor businesses over employees and consumers.” *Id.* at 424.

²⁴⁰ “Naturally” because the state qua state challenged federal legislation, and individuals did not join the state. Thus, the only element of the *Dole* analysis that incorporated individuals (if any) was the idea of spending for the general welfare. See 483 U.S. at 207.

²⁴¹ See Daniel A. Farber, *Another View of the Quagmire: Unconstitutional Conditions and Contract Theory*, 33 FLORIDA ST. U. L. REV. 913, 914, 926-31 (2007) (surveying the caselaw and the literature regarding unconstitutional conditions and noting that it is a “swamp”).

²⁴² Sunstein, *supra* note 27, at 593-94.

²⁴³ LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW*, § 10-8, 681 (2d ed. 1988).

²⁴⁴ *Id.*

²⁴⁵ See *id.*; see note 214, *supra*, and accompanying text.

Further, the unconstitutional conditions doctrine is an uncomfortable fit for both the pure funding statutes and the conscience clause funding statutes because of the various levels at which the funding and attendant conditions operate. At the first level, the pure funding statutes reflect federalism; the state can accept or reject the funding depending on whether the elements of the *Dole* test are met, most importantly (to the Court) the clear notice requirement.²⁴⁶ But a second level exists beyond the state acceptance of federal funds. This is the level at which the individual who relies on the federal spending program has the conditions imposed that were accepted by the state or other intermediary. This second level is unrepresented in either the *Dole* analysis or the traditional unconstitutional conditions analysis. In the first, only the federal-state relationship is discussed. In the second, the Court tends to assume a direct bargaining relationship between the federal government and the individual that tends not to be present.

Consider again the Medicaid program. Its legal entitlement extends to both the state and the individual enrollee. So long as the state adheres to its State plan, the federal government must continue to provide matching funds, but those funds come with certain conditions. Many of those conditions operate on the state; in other words, they require the state to adhere to certain rules regarding the administration of the program, such as comparability.²⁴⁷ But, many of those conditions also benefit or burden the state’s Medicaid enrollees, who have no part in the creation of the State plan or the state’s acceptance of the federal conditions, as well as the healthcare providers who agree to treat enrollees.²⁴⁸ Thus, though the Court undertook an unconstitutional conditions analysis in *McRae* and *Maher* (albeit a flawed one), it failed to account for the nature of the conditional spending.

Other pure funding statutes contain similar features; the federal government bargains with an intermediary (the state, a clinic) that may not represent the individual beneficiary well enough to consider acceptance of the condition a true waiver of constitutional rights.²⁴⁹ The conscience clause funding statutes magnify the issue; in exchange for federal funding of any kind, healthcare providers must permit unspecified moral objections to reproductive health services. Both models permit indirect violation of constitutional rights, particularly women’s reproductive rights, and the incursions are deliberate. The question then is how to connect the Spending Clause jurisprudence to the individual so that such intentional, yet indirect, attacks by use of conditioned federal funds are at least recognized if not prevented.

One avenue would be to apply the existing *Dole* framework to the individual, not just the state; if the Court were to apply the *Dole* test in such a way that it is conjunctive (rather than selective), it may analyze fully conditional spending. The analysis in the prior section of this paper indicates that *Dole* may be up to the task. This would require the Court to analyze germaneness and coercion, which has occurred on rare occasion. For instance, in *Nollan v. California Coastal Commission*, decided in the same term as *Dole*, the Court considered conditions placed on landowners who wanted to build a home that would block public beach access.²⁵⁰ Though a property case, Justice Scalia’s majority analyzed the state’s imposition of the condition (an easement) using a germaneness analysis. The Court held that, because the

²⁴⁶ See *South Dakota v. Dole*, 483 U.S. at 207; *Arlington*, 126 S.Ct. at 2459.

²⁴⁷ See note ___ and accompanying text, *infra*.

²⁴⁸ Professor Farber refers to this as “third-party effects,” meaning that the government bargains with an intermediary who may or may not actually represent the interests of the individual whose constitutional rights are at issue. See Farber, *supra* note 241, at 935.

²⁴⁹ As Professor Farber observed, the Court has allowed many constitutional rights to become “alienable.” *Id.* at 917-26.

²⁵⁰ *Nollan v. California Coastal Commission*, 483 U.S. 825 (1987).

condition was required for obtaining the necessary building and land use permits, the state was able to “extort” the easement out of the property owner without paying for the taking of the property, and further the permit condition did not serve the same governmental purpose as the development ban, thereby eliminating any nexus between the ban and the condition.²⁵¹ In other words, germaneness did not exist because the condition was not tailored closely enough to the goal of the law. Some have said that germaneness is unsuited to judicial decision-making, but the Court often determines whether or not a law is properly tailored to the governmental goal, especially when the government infringes individual rights in pursuit of that goal. That the spending power should be exempt from this kind of nexus analysis is unpersuasive.

Likewise, some have asserted that coercion is not judicially determinable, but even *Dole* seems to indicate otherwise, as Chief Justice Rehnquist indicated that some degree of proportionality should be considered.²⁵² South Dakota only jeopardized 5% of the offered federal highway funding if it refused to change the drinking age, and that was not enough to reach the point where “coercion becomes compulsion” because the state would still receive a significant proportion of the offered federal funds if the condition were rejected.²⁵³ On the other hand, in the case of Medicaid, Title X, and SCHIP, failure to comply with conditions can result in complete withdrawal of funding.²⁵⁴ States have asserted that they cannot reject federal conditions; imagine then the position of the Medicaid enrollee. Only the poorest and most vulnerable citizens even qualify for Medicaid funding. The idea that they could negotiate with the federal government regarding conditions on federal funds verges on the absurd.²⁵⁵

V. Conclusion

South Dakota v. Dole facilitated a disconnect that analytically separates the individual from the conditional spending program, a divide that has allowed Congress to impinge on individual rights when it could not otherwise do so using other enumerated powers. At a micro-level, the Court’s decisions have allowed government to burden the privacy right to obtain abortion by withholding funds in public healthcare programs. At the macro level, the power to place conditions on spending has created an end-run that has been quite successful, as exhibited by the multiple pure funding statutes and conscience clause funding statutes that result from the Court’s decisions in *McRae* and *Maher*. The gap that exists here could exist in any federal spending program, but the case of Medicaid is particularly notable given the fragile, disenfranchised status of its enrollees and given the current interest in healthcare reform.

If the federal government is to restructure healthcare programs in an effective, nondiscriminatory manner, the boundaries of its power to spend must be explored and defined.

²⁵¹ *Id.* at 837.

²⁵² See Farber, *supra* note 241, at 947. Farber goes on to discount this interpretation as unworkable because, in his contract analogy, this is about pricing, and the courts are not in the business of ensuring fair pricing. *Id.* at 948.

²⁵³ 483 U.S. at 211.

²⁵⁴ Given the technical structure of the Hyde Amendment, a state would have to seek reimbursement from Medicaid for something other than abortion and then redirect the funds for that purpose, which sounds like it could be too much effort, but it has occurred in hospital financing schemes. See Huberfeld, Bizarre Love Triangle, *supra* note 195, at 466. Of course, this would also create a potential violation of the False Claims Act.

²⁵⁵ The absurdity is highlighted by Professor Ruth Colker in relaying the facts from *Doe v. Maher*, a Connecticut case wherein the state supreme court evaluated the impact of Medicaid funding on poor women’s lives. See Colker, *supra* note 58, at 119.

Currently, underlying doctrines such as the greater includes the lesser theory and the positive/negative rights theory tend to ignore the reality of the modern government, which wields influence through benefits. This article has proposed that, for now at least, the *Dole* test can facilitate drawing such boundaries if all of its elements are actively analyzed by the Court. The current focus on the federal-state relationship does not protect individuals in federal healthcare programs, nor does it particularly protect states. Though individual rights have not appeared to be particularly important to the majority of the Roberts Court, protecting the states through active federalism doctrine may be. This article also has proposed that Congress can change this trend, in a microcosm, by eliminating the Hyde Amendment and other pure funding statutes as well as by balancing conscience clause funding statutes. Conscience clause funding statutes in particular would become potentially unconstitutional under a revitalized *Dole* regime, as the ability to affect private-pay patients through federal spending truly pushes the envelope of the spending power.