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Conditional Spending and Compulsory Maternity

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CONDITIONAL SPENDING AND COMPULSORY MATERNITY†

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More than forty-six million Americans are uninsured, and many more are seeking government assistance, which makes congressional spending for federal programs a significant issue. Federal funding often comes with prerequisites in the form of statutory conditions. This Article examines the impact that conditions placed on federal healthcare spending have on the individuals who rely on that spending by exploring the ongoing disconnect between Spending Clause jurisprudence and women's reproductive rights. The first Part reviews the foundational Supreme Court precedents and places them in context from both a statutory and theoretical perspective. The second Part studies what the author denominates "pure funding statutes" and "conscience clause funding statutes." The third Part explores the contours of conditional spending jurisprudence in an effort to determine where individual protection may fit within the existing conditional spending jurisprudence. The Article concludes that the Supreme Court could protect the interests of individuals if its existing conditional spending test is applied in full, which has not been the Court's practice. The Article also concludes that, given the makeup of the Roberts Court and the balance of Congress, the better solution could be legislative constitutionalism. In other words, Congress should remove these funding limitations from legislation—not only because such limitations may be unconstitutional but also because they represent an ongoing disconnect in the law that aggrandizes the spending power.

† Reva 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.* at 308–10. 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.*

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TABLE OF CONTENTS

I. INTRODUCTION

Lack of health insurance is widely understood to create a barrier to healthcare services in the United States.[1] At a time when more than forty-six million Americans are uninsured,[2] and many more are seeking government assistance to access healthcare due to job losses and em-

1. *See* SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, LOSING GROUND: HOW THE LOSS OF ADEQUATE HEALTH INSURANCE IS BURDENING WORKING FAMILIES 14–15 (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); KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE UNINSURED: A PRIMER 8 (2009), http://www.kff.org/uninsured/upload/7451-05.pdf (reporting that the uninsured are more likely to forego or postpone medical care than the insured; one statistical example given is that about twenty-four percent of uninsured adults had to forgo care in 2008 because of cost, compared to four percent of those covered by private health insurance); KAISER FAMILY FOUND., WOMEN'S HEALTH INSURANCE COVERAGE FACT SHEET 2 (2008), http://www.kff.org/womenshealth/upload/6000_07.pdf ("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 . . . .").

2. According to the United States Census Bureau, the number of uninsured was 46.3 million in 2008. CARMEN DENAVA-WALT, BERNADETTE D. PROCTOR & JESSICA SMITH, U.S. CENSUS BUREAU, INCOME, POVERTY AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2008, at 20 (2009), http://www.census.gov/prod/2009pubs/p60-236.pdf.

ployment benefit cutbacks,[3] the conditions placed on government spending for healthcare are a particularly current issue. The expansion of the Children's Health Insurance Program (CHIP) in the first weeks of the Obama administration signaled that the federal government may be willing to respond to this nationwide need, but federal funding often demands a sacrifice from the recipient, known as conditions on spending.[4] 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.[5] The nation's major public healthcare programs, such as Medicare, Medicaid, and CHIP, are all conditional spending programs.[6] 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's ability to place conditions on federal funds.[7] 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.[8] Knowing that Congress could not place direct obstacles in the path of all

3. *See* Kevin Sack & Katie Zezima, *Growing Need for Medicaid Puts Added Financial Burden on States*, N.Y. TIMES, Jan. 22, 2009, at A25, *available at* http://www.nytimes.com/2009/01/22/us/22medicaid.html.

4. *See* Robert Pear, *Obama Signs Children's Health Insurance Bill*, N.Y. TIMES, Feb. 5, 2009, at A4, *available at* http://www.nytimes.com/2009/02/05/us/politics/05health.html?scp=2&sq=SCHIP&st=cse.

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

6. *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, 10 (2006).

7. *See Dole*, 482 U.S. at 203–04.

8. Representative Hyde stated during the floor debate of the so-called Hyde Amendment: "I certainly would 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." 123 CONG. REC. 19,700 (1977) (statement of Rep. Hyde).

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.[9]

Second, the Hyde Amendment and its progeny serve as a microcosm for studying the ways in which conditional federal spending impacts individuals, particularly those who are most vulnerable. Studies show that funding remains one of the greatest obstacles to healthcare access generally[10] and abortion access specifically for poor women, who forego basic needs, seek unsafe abortions, or are forced to bear the child.[11]

Third, the Hyde Amendment helped to lay the foundation for the jurisprudence allowing such use of conditional spending, which can be found in the 1977 decision *Maher v. Roe*[12] and the 1980 decision *Harris v. McRae*.[13] 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."[14] 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.[15] 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 denominates "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

9. *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 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). *See* Omnibus Appropriations Act, 2009, Pub. L. No. 111-8, div. F, tit. V, §§ 507–508, 123 Stat. 524, 802–03.

10. For example, according to recently published data, forty percent of uninsured women did not have a Pap test, compared to twenty percent of insured women; fifty-one percent of uninsured women did not have a regular doctor, whereas only twelve percent of insured women had no regular doctor; and sixty-seven percent of uninsured women needed care but did not get it due to cost, compared to nineteen percent of insured women. KAISER FAMILY FOUND., *supra* note 1, at 2.

11. *See* 123 CONG. REC. 19,700–01 (1977) (statement of Representative Hyde) (noting that studies he had read indicated women on welfare would bear the children and not seek unsafe abortions); *see also* Marlene Gerber Fried, *The Hyde Amendment: Thirty Years of Violating Women's Rights*, OVERBROOK FOUND. NEWSL. (Overbrook Found., New York, N.Y.), Winter 2006, http://www.overbrook.org/newsletter/06_11/pdfs/hrs/Civil_Liberties_And_Public_Policy_Program.pdf.

12. 432 U.S. 464, 474, 480 (1977).

13. 448 U.S. 297, 308–09 (1980).

14. *See id.* at 316–17.

15. *See id.*

16. *See* discussion *infra* Part III.

the law between the condition on spending and the individual generally and protecting women's reproductive access specifically. Further, Bush administration Department of Health and Human Services (DHHS) regulations would have allowed healthcare providers to thwart women's efforts to obtain certain health services and jeopardized not only access to abortion, but also to contraception, which stretches the *Maher* and *McRae* precedents to their limits.[17]

The national import of conditional spending programs such as Medicaid cannot be overstated,[18] but the use of their power to blockade the exercise of constitutionally protected 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 by the physicians and other healthcare providers who are most affected by conditions on spending.[19] 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 explores the disconnect between Spending Clause jurisprudence and individual 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 intergovernmental 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 reviews 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 studies 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 individuals who rely on federal healthcare programs both for benefits and for recompense. The third Part of this

17. Ensuring that DHHS Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 78,072, 78,072 (Dec. 19, 2008) (to be codified at 45 C.F.R. pt. 88).

18. *See* Sara Rosenbaum, *supra* note 6, at 6. 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 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. (citation omitted).

19. *See id.* at 46 (discussing the participation of physicians and hospitals in such plans).

Article explores 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 Part explores 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 Part provides some background to place the jurisprudence in context. Ultimately this Part shows that the caselaw has two distinct but interrelated threads: first, conditional federal funding impacts state law in important ways; and second, governmental denial of funding affects individuals' ability to exercise their rights. The problem addressed herein lies at the cross-section of these two theoretical strands.

A. Statutory and Theoretical Context

The caselaw is best 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 legislation to Medicare in 1965.[20] 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, the blind, and the disabled—and who also met the government's definition of poverty.[21] 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.[22] Thus, even though each state has its own plan, the Medicaid Act deliberately requires all states to ensure that all Medicaid enrollees, statewide, have

20. *See* Medicaid Act, Pub. L. No. 89-97, 79 Stat. 343 (1965) (codified as amended at 42 U.S.C. §§ 1396–1396w-2 (Westlaw through Feb. 2009 amendments)); ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA 51–53 (1974).

21. *See* STEVENS & STEVENS, *supra* note 20, at 57.

22. 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. *Id.* at 59.

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.[23] In so mandating, Congress departed from the predecessor legislation, known as Kerr-Mills, which had provided healthcare funding to the states with little guidance.[24] 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).[25] 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.[26] One such theory is the positive/negative rights theory of constitutionally protected individual rights.[27] 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).[28] Those who want to limit the legal entitlement also tend to want to describe constitutional rights as negative in nature.[29] The negative/positive dichotomy is a convenient method 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."[30] In the context of the power to spend,

23. *See* STEVENS & STEVENS, *supra* note 20, at 65–66.

24. *See* Kerr-Mills Social Security Act, Pub. L. No. 86-778, 74 Stat. 924 (1960); STEVENS & STEVENS, *supra* note 20, at 51, 66–67.

25. *See* STEVENS & STEVENS, *supra* note 20, at 65–66.

26. 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 n.98 (1981).

27. *See id.* at 734–35 n.99.

28. *See id.* at 734–38 (describing the negative/positive rights theory and applying it to the abortion-funding cases).

29. *See id.* at 734–35.

30. Seth F. Kreimer, *Allocational Sanctions: The Problem of Negative Rights in a Positive State*, 132 U. PA. L. REV. 1293, 1326 (1984); *see also* DeShaney v. Winnebago County Dep't of Soc. Servs., 489 U.S. 189, 191 (1989) (holding that a state social services agency did not violate the constitutional rights of a child who was being abused by his father when the agency recorded the suspected abuse but did not protect the child from his father, who ultimately beat the child so badly that he became permanently and severely mentally retarded). Justice Brennan's dissent pointedly rejected the majority's description of and reliance on the positive/negative rights distinction. *DeShaney*, 489 U.S. at 203–05 (Brennan, J., dissenting). Justice Brennan wrote:

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.[31]

The positive/negative rights theory overlays another substrate, the "greater includes the lesser" theory of government spending.[32] 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.[33] 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.[34] 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.[35]

> I would recognize, as the Court apparently cannot, that "the State's knowledge of [an] individual's predicament [and] its expressions of intent to help him" can amount to a "limitation . . . on his freedom to act on his own behalf" or to obtain help from others. . . .
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> . . . .
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> . . . To put the point more directly, . . . a State's prior actions may be decisive in analyzing the constitutional significance of its inaction. . . .
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> . . . .
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> As the Court today reminds us, "the Due Process Clause of the Fourteenth Amendment was intended to prevent government 'from abusing [its] power, or employing it as an instrument of oppression.'" My disagreement with the Court arises from its failure to see that inaction can be every bit as abusive of power as action, that oppression can result when a State undertakes a vital duty and then ignores it.

Id. at 207, 208, 211–12 (alteration in original) (citations omitted) (citing the majority opinion).

31. *See* Kreimer, *supra* note 30, at 1296–97 ("The greatest force of a modern government lies in its power to regulate access to scarce resources.").

32. *See* Kreimer, *supra* note 30, at 1304–14 (describing and deconstructing the theory); 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").

33. The theory is most often attributed to Justice Holmes, who articulated the "greater includes the lesser" theory in a variety of contexts (not just government spending). *See, e.g.*, Hammer v. Dagenhart, 247 U.S. 251, 277 (1918) (Holmes, J., dissenting); W. Union Tel. Co. v. Kansas, 216 U.S. 1, 54 (1910) (Holmes, J., dissenting).

34. Kreimer, *supra* note 30, at 1304 n.31.

35. *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, *The Prices of Rights: Toward a Positive Theory of Unconstitutional Conditions*, 75 CORNELL L. REV. 1184, 1190 & 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); 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

These three background points help to illuminate the themes that emerge in the caselaw. Conditional federal funding clearly has had an impact on state law; indeed, as is discussed below, the conditional spending test from *South Dakota v. Dole* focuses only on the federal-state relationship.[36] When the state does not deliver the conditional spending benefits, individuals sometimes have been prevented from enforcing the benefits created by the conditions the federal government imposed on the state, leaving them with no recourse when the state's failure harms the individual.[37] Under the "greater includes the lesser" theory, and for those jurists that adhere to a negative rights theory of the Constitution, this is the desired outcome.[38] The Court's rejection of individual enforcement efforts emphasizes the problem described herein, that the individual is deliberately removed from the conditional spending analysis, even when Congress intended that the individual benefit from the conditional spending scheme.[39]

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.[40] An enormous amount of litigation has followed *Roe*, but one strain can be singled out—those cases related to government funding. This line of cases can be traced to *Singleton v. Wulff*,[41] which often is cited for recognizing and exploring exceptions to the third-party standing prohibition.[42] 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.[43] In evaluating Missouri's prohibition on use of Medicaid

Spending Clause jurisprudence as the "'greater includes the lesser' argument" and noting that the Rehnquist Court was unlikely to abandon this approach); Kreimer, *supra* note 30, at 1308–09 (describing Justice Rehnquist's reliance on the doctrine).

36. *See infra* Part IV.B.

37. *See* Blessing v. Freestone, 520 U.S. 329, 333, 344 (1997); Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. DAVIS L. REV. 413, 428–38 (2008) (describing the progression of cases that initially allowed § 1983 causes of action broadly and that has narrowed individual access to the courts through § 1983 over time).

38. *See* Huberfeld, *supra* note 37, at 429–30; *see also* Sunstein, *supra* note 32, at 598–99.

39. Though this Article focuses on federal spending, state and local spending create similar problems, especially when the state or local government refuses to fund the exercise of a fundamental right. *See, e.g.*, Poelker v. Doe, 432 U.S. 519, 521 (1977) (holding that a city's refusal to fund "nontherapeutic" abortions in a local public hospital, while funding childbirth, did not violate the Equal Protection Clause because, based on *Maher v. Roe*'s holding, a Constitution of negative rights does not require the government to fund the exercise of positive rights (citing Maher v. Roe, 432 U.S. 464 (1977)).

40. Roe v. Wade, 410 U.S. 113, 129 (1973).

41. 428 U.S. 106 (1976).

42. *See, e.g.*, Domino's Pizza, Inc. v. McDonald, 546 U.S. 470, 479 (2006); Campbell v. Louisiana, 523 U.S. 392, 397 (1998); Powers v. Ohio, 499 U.S. 400, 410 (1991).

43. 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

funds for so-called nontherapeutic 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 [sic] being paid by the State. The woman's exercise of her right to an abortion, whatever its dimension, is therefore necessarily at stake here."[44] 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."[45] Though these statements were support for the standing principles enunciated by the Court, they showed recognition that funding is an obstacle for poor women making reproductive decisions.[46]

Four years after *Roe v. Wade* was decided, the Court heard the companion cases *Beal v. Doe* and *Maher v. Roe*.[47] *Beal* held that the Medicaid Act did not require states to pay for nontherapeutic abortions, a decision based on statutory interpretation.[48] *Maher* involved a Connecticut law that limited state Medicaid benefits to medically necessary first trimester abortions.[49] Justice Powell's majority held that states do not violate the Equal Protection Clause if they choose not to fund nontherapeutic 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.[50] 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 classification[51] and the law otherwise passed rational basis re-

policy for both themselves and their patients. *See Singleton*, 428 U.S. 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.

44. *Id.* at 117.

45. *Id.*

46. Justice Powell, 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, focused on this in his dissent. *See id.* at 128–29 (Powell, J., dissenting).

47. Maher v. Roe, 432 U.S. 464 (1977); Beal v. Doe, 432 U.S. 438 (1977). It also heard *Poelker v. Doe*, 432 U.S. 519, 521 (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).

48. 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*, 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) (1976). The Court called abortion "*unnecessary*—though perhaps desirable—medical services," which the state was not obliged to cover. *See Beal*, 432 U.S. at 444.

49. *Maher*, 432 U.S. at 466.

50. *Id.*

51. Justice Powell wrote:

view.[52] The Court stated that even though medical costs associated with carrying a pregnancy to term are much higher than paying for abortion, the state's decision was rational because the state may encourage "normal" childbirth,[53] which the Court did not deem to be an "obstacle" for poor women.[54] 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."[55] This dicta suggests that maternity may be imposed on women who depend on government funds for medical care,[56] a Victorian notion that also implicates the fundamental right to procreate.[57]

Further, while states had always had some flexibility in the Medicaid program, allowing states to shun one particular medical procedure that would otherwise be covered as an outpatient hospital or physician service ignored the statutory framework of the Medicaid Act[58]—as well as its purpose, to ensure that indigent citizens would have equal access to medically necessary services.[59] Medicaid was created to secure medical assistance for individuals "whose income and resources are insufficient to meet the costs of necessary medical services."[60] 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

> The Connecticut regulation places no obstacle—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.

52. *See id.* at 479. Justice Powell urged that

> [t]here 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 475–76.

53. The district court found this financial decision on the part of the state to be irrational. *See id.* at 468.

54. *Id.* at 474.

55. *Id.* at 478 n.11.

56. 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 (D. Conn. 1975).

57. *Compare* Skinner v. Oklahoma, 316 U.S. 535 (1942) (holding that the right to procreate is a fundamental liberty), *with* Buck v. Bell, 274 U.S. 200 (1927) (holding that mandatory sterilization is within the State's powers).

58. 42 U.S.C. §§ 1396–1398w-2 (Westlaw through Feb. 2009 amendments).

59. *See* STEVENS & STEVENS, *supra* note 20, at 57.

60. *Id.*; *see also* 42 U.S.C. §§ 1396–1396w-2 (Westlaw through Feb. 2009 amendments).

labor and delivery.[61] Denying Medicaid payment, then, effectively foreclosed indigent women from obtaining this medical care.[62] 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.[63] 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*.[64] 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.[65] The Court analyzed the most restrictive version of the Hyde Amendment, a provision that only permitted use of Medicaid funds in very limited circumstances.[66] The Court found that states were not required to pay for services that the federal government would not fund, because Medicaid is a cooperative federalism program that involves matching funds, not unfunded mandates.[67]

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.[68] Instead, the majority determined that the Hyde Amendment, like the law at issue in *Maher*, encouraged an activity "deemed in the public interest."[69] 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 neces-

61. *See* Sylvia A. Law, *Childbirth: An Opportunity for Choice that Should Be Supported*, 32 N.Y.U. REV. L. & SOC. CHANGE 345, 372–77 (2008) (describing how definitions of medical necessity and courts' interpretations of that terminology are at odds with women's health needs).

62. *See* Beal v. Doe, 432 U.S. 438, 455 (1976) (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 459–60.

63. *See id.* at 462–63 (Blackmun, J., dissenting).

64. 448 U.S. 297 (1980).

65. *Id.* at 297.

66. *Id.* at 302–03. This was an important difference from *Maher*, in which Connecticut was paying for so-called medically necessary abortions. Maher v. Roe, 432 U.S. 464, 466 (1977). 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. *McRae*, 448 U.S. at 302–03.

67. *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.

68. *Id.* at 314–15.

69. *Id.* at 315.

sary services are not covered.[70] The Court also refused to consider that the Hyde Amendment was a violation of the Equal Protection Clause.[71]

Justice Brennan's dissent noted, however, that refusal to pay is a deliberate effort to prevent the exercise of a constitutionally protected right.[72] Justice Brennan described the Hyde Amendment as a withdrawal of funds for medically necessary services that would otherwise be paid for by Medicaid.[73] 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.[74]

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.[75] 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 child, becomes its deadly adversary, then it is the duty of this legislature to intervene . . . ."[76] The Court's lack of analysis regarding this clear legislative history is startling, given how

70. *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." *Id.* 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.

71. *Id.* at 322–23. A number of scholars have critiqued the decision based upon its Equal Protection analysis (or lack thereof). *See, e.g.*, Ruth Colker, Essay, *Equality Theory and Reproductive Freedom*, 3 TEX. J. WOMEN & L. 99, 102–16 (1994); Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 270 n.28 (1992); Sunstein, *supra* note 32, at 617–19.

72. *McRae*, 448 U.S. at 330 (Brennan, J., dissenting).

73. *Id.* at 329.

74. *Id.* at 330–31.

75. 123 CONG. REC. 19,700 (1977) (statement of Rep. Hyde).

76. *Id.* at 19,701. 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 71, 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, 209–10 (1976); *see also* LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW 1561–65 (2d ed. 1988).

open the proponents of the Hyde Amendment were about their goals.[77] Representative Hyde even stated that he knew that women would not have access to abortion if Medicaid did not pay for it; yet, the Court did not mention or discuss this questionable funding condition.[78]

Ten years later, *Rust v. Sullivan* continued the reasoning of *Maher* and *McRae*.[79] *Rust* involved the Public Health Services Act (Title X) Funding for Family Planning Clinics, 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.[80] The statute forbids granting federal funds to "programs where abortion is a method of family planning."[81] 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.[82] Describing the "authority" the government possesses under *McRae* and *Maher*, the Court held that Congress could refuse to fund both abortions and abortion counseling to promote childbirth.[83] 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.[84] 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.[85] 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.[86] 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 *Maher*.[87] 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

77. 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, 1121 (1980).

78. 123 CONG. REC. 19,700–01 (1977) (statement of Rep. Hyde).

79. Rust v. Sullivan, 500 U.S. 173, 192–93 (1991).

80. 42 U.S.C. §§ 300–300a-6 (2006).

81. *Id.* § 300a-6.

82. *Rust*, 500 U.S. at 181.

83. *Id.* at 192–93.

84. *Id.* at 193, 201.

85. Though *Rust* was heard after *South Dakota v. Dole*, 483 U.S. 203 (1987), discussed *infra*, the Court did not engage in a Spending Clause analysis. *Rust*, 500 U.S. 173.

86. *Rust*, 500 U.S. at 195 n.4.

87. *Id.* at 196–97.

so that the right to abortion cannot be exercised. In Justice Blackmun's view, this was no different than if the federal government "banned abortions outright."[88]

In 2001, *Legal Services Corp. v. Velazquez*, a case with an analogous issue, was decided in the opposite manner.[89] In *Velazquez*, the Court held that despite the broad power that accompanies federal funding, Congress could not prohibit the Legal Services Corporation (LSC) from representing clients who presented challenges to the welfare program as a whole.[90] The Kennedy majority attempted to distinguish its reasoning 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.[91] The Court distinguished *Velazquez* from *Rust* by reasoning that the women who seek reproductive health counseling at Title X centers had other avenues to learn of abortion and related services.[92] 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.[93] The Court's arguments are unpersuasive, as the impositions on the legal profession are equally troubling for the medical profession. The funding restrictions operate in the same manner; the plaintiffs in *Velazquez* were as limited in hiring private counsel as the plaintiffs in *Rust* were limited in utilizing private funding (and just as women enrolled in Medicaid are limited in seeking private medical services), and each of these limits prevents access to a legal service.

A year after *Rust*, the Court decided *Planned Parenthood of Southeastern Pennsylvania v. Casey*,[94] 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.[95] 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

88. *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.*

89. Legal Servs. Corp. v. Velasquez, 531 U.S. 533 (2001).

90. *Id.*

91. *Id.* at 540–43.

92. *Id.* at 546–47.

93. *See id.* at 553–55 (Scalia, J., dissenting).

94. 505 U.S. 833 (1992).

95. *Id.* at 874.

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."[96] As with *Maher* and *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."[97] Paradoxically, Justice O'Connor further explained: "[F]inding 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."[98] The Court used this language and analysis similar to that in *Maher* and *McRae* to uphold such state obstacles as a twenty-four-hour waiting period between information regarding abortion and performance of the procedure.[99]

Decided fifteen years later by the newly composed Roberts Court, *Gonzales v. Carhart* built on the foundation of the aforementioned precedents.[100] Again, though not a spending case, *Carhart* is relevant to the spending analysis because it continues the reasoning begun in *Maher* and *McRae*.[101] 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*.[102] 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, allowing an ongoing impact on the exercise of individual rights. 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

96. *Id.*

97. 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 v. Wade* was decided. *See* Brief of Petitioners and Cross-Respondents at 2–5, Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992) (No. 91-744) (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).

98. *Casey*, 505 U.S. at 877.

99. *Id.* at 885–86.

100. Gonzales v. Carhart, 550 U.S. 124, 146 (2007).

101. *Id.*

102. *Id.*

particular right in ways that likely would be impermissible for other fundamental rights.[103] 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 federal funding.[104]

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.[105] 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 on religious or moral grounds.[106] The two varieties of statutes have given *Maher* and *McRae* broad influence that may reach beyond the abortion realm into general reproductive services, including contraception and sterilization, for both

103. *See supra* Part II.B.

104. *See* Laurence H. Tribe, *The Abortion Funding Conundrum: Inalienable Rights, Affirmative Duties, and the Dilemma of Dependence*, 99 HARV. L. REV. 330, 331 (1985).

105. *See, e.g.*, 10 U.S.C. § 1093a (2006); 20 U.S.C. § 1688 (2006); 42 U.S.C. § 300a-7b (2006).

106. 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 (arguing that religious exemptions reflected in conscience clauses tend to be constitutionally legitimate but that moral objection clauses may be unprotected); Leslie C. Griffin, *Conscience and Emergency Contraception*, 6 HOUS. J. HEALTH L. & POL'Y, 299, 312–13, 317 (2006) (explaining that the Supreme Court's free exercise jurisprudence allows legislatures to create conscience-based legal exemptions); 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, 808, 832–33 (2007) (arguing 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, 86 (2006) (urging use of the market to balance the rights of pharmacists who have moral objections and patients who seek access to legal prescriptions).

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 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 CHIP.[107] 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 as a response to the decision in *Roe v. Wade*.[108] The Hyde Amendment has been renegotiated and modified each year, which has resulted in the exceptions for rape, incest, and health being dropped, added, and dropped again, but it is always attached to the funding for DHHS, the agency responsible for Medicare, Medicaid, and CHIP.[109] 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.[110] Representative Hyde stated during the floor debate: "I certainly would 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."[111] 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.

107. 42 U.S.C. §§ 1396–1396w-2 (Westlaw through Feb. 2009 amendments) (Medicaid); 42 U.S.C. § 1397ee(c)(1) (2006) (SCHIP).

108. Pub. L. No. 94-439, § 209, 90 Stat. 1418, 1434 (1976).

109. *See, e.g.*, Consolidated Appropriations Act, Pub. L. No. 108-447, div. F, §§ 507(a), 508(a), 118 Stat. 2809, 3163 (2004) (prohibiting federal funds for Health and Human Services programs, including Medicaid, from being used for abortions, except in cases of rape, incest, or if 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, 98 Stat. 3305, 3321 (1984); Pub. L. No. 97-12, § 402, 95 Stat. 14, 95–96 (1981); *see also* 42 C.F.R. §§ 441.200–.208 (2008).

110. Omnibus Appropriations Act, 2009, Pub. L. No. 111-8, div. F, tit. V, §§ 507–508, 123 Stat. 524, 802–03.

111. 123 CONG. REC. 19,700 (1977) (statement of Rep. Hyde). 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 POL'Y REV. 12, 16 (2007), http://www.guttmacher.org/pubs/gpr/10/1/gpr100112.pdf.

1. Medicaid

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.[112] Medicaid is structured to cover the needs of certain "categorically" poor, thus the program only covers about forty percent of all of the nation's poor.[113] 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.[114] 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.[115] Despite these requirements, the Hyde Amendment has been a condition on the federal funding for Medicaid since 1977; though it has not been codified in the Medicaid Act,[116] the ban is written into the regulations for Medicaid.[117] Technically the Hyde Amendment only addresses the DHHS distribution of federal funds; it does not prohibit states from paying for abortion.[118] But states have no obligation to pay for those services that the federal government will not fund (under *McRae*),[119] rendering the Hyde Amendment effectively a condition on federal spending.

Some basic statistics highlight the impact of funding restrictions such as the Hyde Amendment. About twelve percent of all women of childbearing age were enrolled in Medicaid as of 2006, and women comprise sixty-nine percent of the adult beneficiaries in Medicaid.[120] Of the adult women enrolled in Medicaid, nearly two-thirds are of child-bearing age.[121] Medicaid pays for forty-one percent of all births nationally and more than half of the births in certain states.[122] Medicaid covers prenatal care, childbirth, and postnatal services,[123] and coverage of pregnant wom-

112. 42 U.S.C. §§ 1396–1396w-2 (Westlaw through Feb. 2009 amendments).

113. *Id.* § 1396a(a)(10)(A); KAISER FAMILY FOUND., MEDICAID'S ROLE FOR SELECTED POPULATIONS (July 16, 2009), http://facts.kff.org/chart.aspx?ch=464.

114. *See* 42 U.S.C. § 1396a(a)(10)(B). Even states with special waivers (called section 1115 waivers) have to adhere to comparability. *See id.* § 1315 (2006). Under a recent Medicaid modification, however, states with approved plans called Deficit Reduction Act (DRA) benchmark plans need not. *See id.* § 1396u-7.

115. *See id.* § 1396d(a)(2), (4).

116. The abortion restriction was included in the DRA provisions that permitted states to use certain kinds of managed care for Medicaid populations. *See id.* § 1396u-2(e)(1)(B).

117. 42 C.F.R. § 441.200 (2009).

118. Pub. L. No. 94-439, § 209, 90 Stat. 1418, 1434 (1976).

119. Harris v. McRae, 448 U.S. 297, 308 (1980).

120. *See* Boonstra, *supra* note 111, at 12; KAISER FAMILY FOUND., MEDICAID'S ROLE FOR WOMEN 1 (2007), http://www.kff.org/womenshealth/upload/7213_03.pdf [hereinafter MEDICAID'S ROLE FOR WOMEN].

121. *See* MEDICAID'S ROLE FOR WOMEN, *supra* note 120.

122. *See id.*

123. 42 U.S.C. § 1396a(l) (Westlaw through Feb. 2009 amendments).

en is the category with the highest financial threshold for enrollees (at 133 percent of the federal poverty level).[124] Medicaid also funds family planning through an enhanced federal match to states, resulting in Medicaid covering sixty-one percent of all federal spending for family planning, though family planning cannot cover abortion or counseling regarding abortion.[125] In 2009, the federal poverty level for one person was $10,830 and $3,740 was added for each additional person in a household.[126] The women who qualify for Medicaid are extremely poor; they can barely cover 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.[127] Women enrolled in Medicaid tend to be not only of childbearing age and poor but also less educated, minorities, and parents.[128] As of 2004, five percent of white women were covered by Medicaid, while twelve percent of Hispanic women and fourteen percent of African American women were Medicaid enrollees.[129] 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

124. *See* MEDICAID'S ROLE FOR WOMEN, *supra* note 120. Many states cover pregnant women up to 185 percent of the federal poverty level, as permitted by federal law. *See id.*

125. *See id.* The enhanced match is ninety cents to every ten cents states spend; the usual federal match is between fifty percent and seventy-six percent of the state's spending on its Medicaid enrollees depending on the state and its poverty level. *Id.*; *see also* 42 U.S.C. § 1396d(a)(4)(C).

126. *See* Annual Update of the HHS Poverty Guidelines, 74 Fed. Reg. 4199, 4200 (Jan. 23, 2009) (delineating federal poverty guidelines for the Department of Health and Human Services).

127. When the Hyde Amendment was passed, the House contained only eighteen female representatives: "I would say that if there were 417 women in this 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." 123 CONG. REC. 19,708 (1977) (statement of Rep. Holtzman).

128. *See* MEDICAID'S ROLE FOR WOMEN, *supra* note 120.

129. *See* KAISER FAMILY FOUND., WOMEN AND HEALTHCARE: A NATIONAL PROFILE 16 (2005), http://www.kff.org/womenshealth/upload/Women-and-Health-Care-A-National-Profile-Key-Findings-from-the-Kaiser-Women-s-Health-Survey.pdf [hereinafter WOMEN AND HEALTHCARE]. Interestingly, thirty-eight percent of Hispanic women were then uninsured, compared to seventeen percent of African American women and thirteen percent of white women, perhaps indicating an outreach problem. *Id.*

> obtain the same abortion that their wealthier sisters will be able to obtain in any case.[130]

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

Even though rates of abortion have been decreasing nationally, the trends among poor women and women of color tell a different story.[131] 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.[132] Currently, seventeen states use their own funds to provide coverage for abortions that may not be paid for with federal funds.[133] 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.[134] The rate of abortion has been increasing for all poor women since 1994, and black and Hispanic women consistently have abortions at higher rates than white women.[135] Relatedly, between 1994 and 2001, the unintended pregnancy rate rose for Latinas and poor women, which made them more likely to turn to abortion.[136] Women of color and poor women are more likely to delay obtaining an abortion due to the effort to raise money;[137] an abortion in the first trimester on average costs $430, whereas in the second trimester it costs an average of $1260.[138] Given the current federal poverty level, a single woman enrolled in Medicaid in a state that allows childless adults to enroll at one hundred percent of the poverty level can make no more than $902.50 per

130. 123 CONG. REC. 19,710–11 (1977) (statement of Rep. Mitchell).

131. Justice Marshall predicted that they would in *Beal*, 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 appears that almost 40% of minority women . . . are dependent upon Medicaid for their health. 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."

Beal v. Roe, 432 U.S. 438, 459–60 (1977) (Marshall, J., dissenting) (citations omitted).

132. Fried, *supra* note 11, at 2.

133. *See* KAISER FAMILY FOUND., ABORTION IN THE U.S.: UTILIZATION, FINANCING, AND ACCESS (2008), http://www.kff.org/womenshealth/upload/3269-02.pdf [hereinafter ABORTION IN THE U.S.].

134. *See* 123 CONG. REC. 19,709 (1977) (statement of Rep. Weiss); *see also* ADAM SONFIELD ET AL., GUTTMACHER INST., OCCASIONAL REPORT NO. 38, PUBLIC FUNDING FOR FAMILY PLANNING, STERILIZATION AND ABORTION SERVICES, FY 1980–2006, at 18 (2008) (finding that 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).

135. *See* ABORTION IN THE U.S., *supra* note 133. A 2002 study showed African American women's abortion rates to be 49/1000 and Hispanic women's rates to be 33/1000, whereas European American women's rate was 13/1000. *Id.*

136. *See* HEATHER D. BOONSTRA ET AL., GUTTMACHER INST., ABORTION IN WOMEN'S LIVES 26–28 (2006), http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf.

137. *See id.* at 29.

138. ABORTION IN THE U.S., *supra* note 133.

month to remain qualified for Medicaid.[139] 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.[140]

2. CHIP

CHIP is a spending program that provides federal funds to states to provide healthcare coverage to low-income uninsured children and their families.[141] CHIP 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, CHIP limits the federal funds provided to states and specifically is not an entitlement for its enrollees.[142] Also, whereas Medicaid covers several categories of eligible enrollees, CHIP was written specifically to cover children who do not qualify for Medicaid but who are near-poor (states decided to cover their parents too).[143] Finally, whereas Medicaid imposes no limit to the federal match, CHIP is capped at a set federal dollar amount each year.[144]

The Hyde Amendment would have affected CHIP as it affects Medicaid; the Amendment forbids DHHS to spend federal funds on abortion in most circumstances,[145] and DHHS administers CHIP.[146] When CHIP was enacted in 1997, however, the Hyde language was written into the legislation rather than depending on an annual rider.[147] As with Medicaid, CHIP funds may not be used for abortion except in extraordinary circumstances: "[A]ny health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life

139. *See* KAISER FAMILY FOUND., WHERE ARE STATES TODAY? MEDICAID AND STATE-FUNDED COVERAGE ELIGIBILITY LEVELS FOR LOW-INCOME ADULTS (2009), http://www.kff.org/medicaid/upload/7993.pdf.

140. Geography and state waiting periods add additional financial hurdles. *See* Colker, *supra* note 71, at 116–20 (discussing the role poverty should play in reproductive rights analysis). Reporting in early 2009 indicated an increase in abortions and vasectomies due to the economic recession, which is consistent with the decision making occurring among the poor already. David Crary & Melanie S. Welte, *Doctors See Economic Impact on Abortion, Birth Control*, USA TODAY, Mar. 24, 2009, http://www.usatoday.com/news/health/2009-03-24-family-planning_N.htm. Women who have participated in studies regarding who has abortions and the reasons for the procedure have consistently indicated that lack of financial resources is a primary reason for having an abortion. *See* LAWRENCE B. FINER ET AL., GUTTMACHER INST., REASONS U.S. WOMEN HAVE ABORTIONS: QUANTITATIVE AND QUALITATIVE PERSPECTIVES 112–13, 115 (2005), http://www.guttmacher.org/pubs/psrh/full/3711005.pdf.

141. 42 U.S.C. § 1397aa (Westlaw through Feb. 2009 amendments).

142. *See id.* § 1397bb(b)(4).

143. *See id.* § 1397aa(a).

144. *See id.* § 1397dd(b).

145. Pub. L. No. 94-439, § 209, 90 Stat. 1418, 1434 (1976).

146. *See* 42 U.S.C. § 1315 (2006).

147. *Id.* § 1397ee(c)(1).

of the mother or if the pregnancy is the result of an act of rape or incest."[148]

Many of the demographics that exist within Medicaid are also true for CHIP. Though teenage pregnancy had been declining from 1990 until 2004, an increase in teen pregnancy occurred between 2005 and 2006.[149] Teen abortion rates have also been falling, but both the pregnancy rates and the abortion rates are higher among African American and Hispanic teens.[150] Again, many of the statistics and demographics are reminiscent of Medicaid.[151] The CHIP pure funding limitations are potentially more constant, because the CHIP funding limitation is written as a condition of receiving federal funds within the CHIP statute itself.[152] Also, the restrictions in CHIP are a deliberate limitation on minors' access to reproductive health services, a group that would have even more difficulty accessing healthcare than most given that minors often need parental support in the form of consent, financial contributions, and the like to access healthcare services.

3. Other Federal Programs

Legislators have added Hyde-style language to other appropriations bills, thereby denying federal funding for abortion coverage in varied programs such as federal employees,[153] federal prisoners,[154] military personnel and their families,[155] Native Americans,[156] Peace Corps volunteers,[157] and foreign aid programs.[158] Many of the spending limitations that can be described as pure funding statutes are appropriations bill riders, much like the Hyde Amendment.

148. *Id.*; *id.* § 1397jj(a)(16).

149. *See* KAISER FAMILY FOUND., SEXUAL HEALTH OF ADOLESCENTS AND YOUNG ADULTS IN THE UNITED STATES 1 (2008), http://www.kff.org/womenshealth/upload/3040_04.pdf.

150. *See id.*

151. *See supra* notes 135–36 and accompanying text.

152. *See* 42 U.S.C. § 1397ee(c)(1).

153. Federal Employees Health Benefits Program funding facilitates this limitation. *See* Consolidated Appropriations Act, Pub. L. No. 110-161, §§ 615–616, 121 Stat. 1844, 2015 (2008) (allowing payment only in instances of life endangerment, rape, or incest).

154. *Id.* §§ 202–204, 121 Stat. at 1912–13. 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.*

155. 10 U.S.C. § 1093(a) (2006).

156. Indian Health Service Act, 25 U.S.C. § 1676 (2006).

157. Foreign Operations, Export Financing, and Related Programs Appropriations Act, Pub. L. No. 109-102, 119 Stat. 2172, 2184 (2006).

158. *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 & Michael Shear, *Funding Restored to Groups that Perform Abortions, Other Care*, WASH. POST, Jan. 24, 2009, at A3. 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. *Id.*

Hyde-style language has had some severe results. For example, the healthcare program for military members and their families, known as the TRICARE program,[159] contains the following prohibition: "Funds 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."[160] 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.[161] A recent case highlights the brutal implications of this limitation.[162] Mrs. Britell was the wife of an Air National Guard captain and in the midst of a highly desired pregnancy but learned that the fetus was anencephalic.[163] 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.[164] 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.[165] As the district court noted, TRICARE pays for all medically necessary healthcare services but excludes abortion, including abortion for severe fetal abnormalities, from the payment scheme.[166] 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.[167] 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

159. 10 U.S.C. § 1072(7) (defining the TRICARE program).

160. *Id.* § 1093(a).

161. 32 C.F.R. § 199.4(e)(2) (2008). 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:

> *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, OCHAMPUS, or a designee, shall issue guidelines describing the policy on abortion.

32 C.F.R. § 199.4(e)(2) (emphasis added).

162. *Britell*, 204 F. Supp. 2d at 182.

163. *Id.* at 183.

164. *Id.*

165. *Id.* at 183–84.

166. *See id.* at 183.

167. *Id.* at 184.

McRae, the regulation was impermissible, as no legitimate state interest is served by forcing a woman to continue pregnancy with a brain-absent fetus.[168]

On appeal, the Federal Circuit reversed and held that the government acted pursuant to the legitimate interest in promoting potential life.[169] Relying on *McRae* and *Maher*, the circuit 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.[170] The circuit court, in so holding, essentially determined that anencephaly is not always terminal, despite scientific evidence and trial court findings to the contrary.[171] The *Britell* holding has traction, though, because of *McRae* and *Maher*.[172] *Britell* also displays the deferential analysis that has occurred in these cases. Even assuming rational basis review is the correct standard, it does not mean that courts must give the federal government a free pass on conditions on spending that are neither legitimate nor rational.[173]

Another example of the pure funding statutes is Title X, which prohibits use of federal funds for abortion (or abortion counseling).[174] The "Gag Rule" upheld in *Rust v. Sullivan*[175] states that "[n]one of the funds appropriated under this subchapter shall be used in programs where abortion is a method of family planning."[176] 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.[177] The clinics could provide such counseling so long as it is separated from the federal funding, but in reality clin-

168. *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.

169. Britell v. United States, 372 F.3d 1370, 1372–73 (Fed. Cir. 2004).

170. *See id.* at 1380–82.

171. *See id.* at 1382.

172. *See id.* at 1383–84; *see also* Perry, *supra* note 77, 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.

173. 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 Ctr., Inc., 473 U.S 432 (1985); Reed v. Reed, 411 U.S. 677 (1973).

174. 42 U.S.C. § 300a-6 (2006).

175. *See supra* text accompanying notes 79–88.

176. 42 U.S.C. § 300a-6; Rust v. Sullivan, 500 U.S. 173, 192–93 (1991). 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) (2008). Conscience clause funding limits, however, may affect this regulation, as discussed below.

177. 42 U.S.C. § 300a-6.

ics cannot create such a "Chinese wall" and often must forgo abortion counseling or referrals to secure much needed federal funding.[178]

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 *infra*). 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 drastic in the case of conscience clause funding statutes, which affect both the healthcare provider and the funding recipient in surprising 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 examined the First Amendment implications for conscience clause funding statutes,[179] the use of conditions on federal funding to facilitate federal conscience clauses has not been explored. Three conscience clause funding statutes merit brief description, as they form the basis for a regulation that would have greatly expanded the scope of conscience clause funding statutes.[180]

The Church Amendments, which were originally part of Hill-Burton hospital funding, currently apply to the receipt of federal funds

178. *See, e.g.*, Nadine Brozan, *Some Clinics Plan to Advise and Forgo Aid*, N.Y. TIMES, May 24, 1991, at A1; Tamar Lewin, *Abortion Rules Force Clinic to Weigh Money and Mission*, N.Y. TIMES, June 26, 1991, at A1.

179. *See supra* note 106.

180. Ensuring that DHHS Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 78,072, 78,072 (Dec. 19, 2008) (to be codified at 45 C.F.R. pt.88).

related to the Public Health Service Act, the Community Mental Health Centers Act, and the Developmental Disabilities Services and Facilities Construction Act.[181] 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.[182] 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.[183] 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.[184]

Likewise, the Danforth Amendment to Title X prohibits "[a]bortion-related discrimination in governmental activities regarding training and licensing of physicians."[185] The Danforth Amendment prevents the federal government—and state and local governments that receive 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.[186] 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.[187] The Danforth Amendment intentionally protects refusals to participate in abortion or abortion-related services for any reason, and it is not limited to religious objections.[188]

Congress passed the Weldon Amendment (or "Hyde-Weldon Amendment") in 2004 as part of an omnibus appropriations bill;[189] like the Hyde Amendment, the Weldon Amendment has become a rider to

181. 42 U.S.C. § 300a-7 (named after its sponsor, Senator Frank Church of Idaho).

182. *Id.* § 300a-7(b).

183. *Id.* § 300a-7(c).

184. 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, *id.* § 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 abortions." Pub. L. No. 93-189, § 114, 87 Stat. 714, 716 (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).

185. 42 U.S.C. § 238n.

186. *Id.* § 238n(a).

187. *Id.* § 238n(b).

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

189. Consolidated Appropriations Act, 2005, Pub. L. No. 108-447, §§ 507, 508(d), 118 Stat 2809, 3163.

the annual HHS/Labor/Education appropriations legislation.[190] The Weldon Amendment allows publicly funded institutions to refuse to provide abortion care and referrals.[191] Like the Danforth Amendment, the Weldon Amendment is drafted with broad 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."[192]

The Church Amendments, the Danforth Amendment, and the Weldon Amendment formed the statutory foundation for a Bush administration regulation that was entitled "Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law."[193] The "conscience regulation" would have required all healthcare providers that receive federal funds to certify compliance with the terms of the Church Amendments, the Danforth Amendment, and the Weldon Amendment.[194] DHHS proposed and adopted the rule after the cutoff date at the end of the presidential term[195] "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."[196] The conscience regulation had 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.[197] The Obama administration, however, has published a proposal to repeal the rule.[198]

Even if the Obama administration revises or eliminates the conscience regulation,[199] it serves to illuminate how conditional funding is wielded in ways that aggrandize the power to spend and create individual rights dilemmas. 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

190. Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, § 508, 121 Stat. 1844, 2209.

191. *Id.*

192. *Id.*

193. 73 Fed. Reg. 78,072 (Dec. 19, 2008) (to be codified at 45 C.F.R. pt. 88).

194. *Id.* at 78,074.

195. *Id.* at 78,089. 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.*

196. *Id.* at 78,072.

197. *Id.* at 78,094.

198. 74 Fed. Reg. 10,207 (Mar. 10, 2009). Though repeal has been proposed, it does not appear to have been completed at this time.

199. *Id.*

to accept that those funds may come with certain conditions.[200] The first response was to a concern that the definition of "healthcare entity" was too broadly and generally stated.[201] The second rejoinder 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.[202] 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."[203] The regulation was so broadly worded, however, 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" would 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.[204]

In other words, DHHS was aware that the regulation protected 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.[205] 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.[206] 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.[207] Then the agency stated support for new programs that will increase access to healthcare for all.[208] Finally, DHHS disagreed that already dis-

200. 73 Fed. Reg. at 78,076, 78,088.
201. *Id.* at 78,076.
202. *Id.*
203. *Id.* at 78,088.
204. *Id.* at 78,077.
205. *See infra* notes 120–40 and accompanying text.
206. 73 Fed. Reg. at 78,080.
207. *Id.*
208. *Id.*

advantaged 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.[209]

The conscience regulation created a certification requirement that also posed a new conditional spending problem.[210] Certification requirements have been successfully used to prosecute civil False Claims Act[211] cases, which open the door to more whistleblower actions.[212] 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.[213] 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.[214]

The conscience regulation is problematic for at least three reasons. First, it significantly expanded the laws upon which it built. 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.[215] DHHS drafted the conscience regulation so that it permitted 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 challenged the conscience regulation in federal court.[216]

209. *Id.* at 78,080–81.

210. 45 C.F.R. § 88.5 (2008).

211. 31 U.S.C. §§ 3729–3731 (2006).

212. *Id.* § 3730.

213. *See* United States *ex rel*. Mikes v. Strauss, 274 F.3d 687, 699–704 (2d Cir. 2001) (delineating and adopting the theories of express false certification, implied false certification, and worthless services).

214. *See* 73 Fed. Reg. at 78,079 (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 Enforcement: The Case of Pharmaceutical Fraud*, 40 U. MICH. J.L. REFORM 281, 303–39 (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).

215. *See* 42 U.S.C. § 238n (2006); Consolidated Appropriations Act, 2005, Pub. L. No. 108-447, § 508, 118 Stat. 2809, 3163 (2004).

216. 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, http://www.allheadlinenews.com/articles/7013760235. In addition, New York is suing DHHS, as are the Planned Parenthood Federation of America, the National Family Planning and Reproductive Health Associa-

Second, federal funding was 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 CHIP 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.[217] 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 pursue her medical options because of the conscience clause funding statutes.[218] By the mechanism of conditions on spending, the federal government maneuvers around *Roe* and *Casey*.

Third, this regulation distended the *McRae* and *Maher* precedents by prioritizing 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 abortion, sterilization, or contraceptive use. Even if one accepts the flawed precedents of *McRae* and *Maher*, those cases applied to federal programs that provide medical assistance to the poor. 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 federal reimbursement. Conditions on federal funds thus affect not only individuals who are the ultimate beneficiaries of the conditional funds but also those who are not.

IV. RECONNECTING SPENDING CLAUSE JURISPRUDENCE

This Part suggests that either Congress or the Court could effectuate divergence from the current constitutionally questionable path. Given the conservative lean of the Court's current majority, changes seem more likely to occur through Congress altering the legacy of *Maher* and *McRae* via legislative action than through the Court revisiting its long-stable precedents.

tion, and the American Civil Liberties Union. *See* John Gever, *States File Suit to Overturn Healthcare Worker 'Conscience Rule'*, MEDPAGE TODAY, Jan. 19, 2009, http://www.medpagetoday.com/PublicHealthPolicy/HealthPolicy/12507.

217. *See* 73 Fed. Reg. at 78,089 (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).

218. Singleton v. Wulff, 428 U.S. 106, 117 (1976).

A. Legislative Constitutionalism

Congress was responsible for creating the conditions that lead to the benchmark *Maher* 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 by exercising that given authority. The ideas described as "legislative,"[219] "popular,"[220] or "political" constitutionalism[221] describe that the Constitution can and should be interpreted and enforced by the legislative branch and that an active polity should look beyond simply relying on adjudication to protect constitutional rights. In this context, Congress could and should 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 protected and 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 would require affirmative legislative action and hard debate. Though the current healthcare reform debate has been highly partisan and the abortion aspect of the debate has been high profile, it appears to reflect a casual willingness to trade women's reproductive health for a larger cause (rather than actual opposition to abortion.) Though this "trade" is unacceptable in many ways, it may indicate that further modifications to the federal healthcare schema could include greater attention to women's health needs.

A model exists for Congress to improve the impact on women of federal programs such as Medicaid. 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 detail the kind of medical coverage that all women should be able to receive at all stages of life.[222] 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."[223] ACOG's intent is to describe minimal basic care for all women,

219. *See, e.g.*, Robert C. Post & Reva B. Siegel, *Legislative Constitutionalism and Section Five Power: Policentric Interpretation of the Family and Medical Leave Act*, 112 YALE L.J. 1943 (2003).

220. *See, e.g.*, LARRY D. KRAMER, THE PEOPLE THEMSELVES: POPULAR CONSTITUTIONALISM AND JUDICIAL REVIEW (2004).

221. *See, e.g.*, MARK TUSHNET, TAKING THE CONSTITUTION AWAY FROM THE COURTS (1999).

222. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, HEALTH CARE FOR WOMEN HEALTH CARE FOR ALL: COVERING SPECIFIC SERVICES IN WOMEN'S HEALTH (2008), http://www.acog.org/departments/govtrel/HCFWHCFA-SpecificServices.pdf.

223. *Id.* at 1.

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.[224]

The ACOG healthcare reform proposal received some congressional attention. On February 11, 2009, Representative Schakowsky and Senator Stabenow presented resolutions in the House and Senate encouraging adoption of the ACOG plan.[225] 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."[226] The concurrent resolutions were merely hortatory, and though they were timely, it now appears that Congress will include Hyde-type language in national healthcare reform legislation.

Admittedly, it seems unlikely that the conscience clause spending statutes will be greatly modified by Congress, even though the conscience regulation has been revisited by the Obama administration. The key would be for Congress to attempt a balance in the conscience clause funding statutes, 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 help to balance what some see as competing fundamental rights.[227]

Congress's refusal to perpetuate the Hyde-type legislative language would go a long way toward erasing the peculiar legacy of *Maher* and *McRae*. Though the Democrats in the House and Senate attempted to create bills that excluded Hyde-type language, it appears that this legacy will carry through in the national health reform under way. This makes the conditional spending authority that facilitated the Hyde Amendment even more important to evaluate, as Congress appears to be exacerbating the limitations on women's healthcare.

224. *Id.* at 1–4.

225. S. Con. Res. 6, 111th Cong. (2009); H.R. Con. Res. 48, 111th Cong. (2009).

226. *See* S. Con. Res. 6; H.R. Con. Res. 48.

227. *See, e.g.*, Wilson, *supra* note 188, at 59 (proposing that such a balance can be achieved at the state level).

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,[228] 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*.[229] South Dakota challenged a minimum drinking age requirement attached to federal highway funding, claiming the condition was unconstitutional.[230] 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.[231] 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.[232] This narrow focus on the federal-state relationship is challenging because programs like Medicaid and CHIP are not just programs that command state compliance with federal law, they are also intended to benefit particular individuals by creating a federal scheme that is to be followed and administered by the states. The *Dole* test fails to account for the individual 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.[233] Chief Justice Rehnquist wrote that courts should defer to the judgment of Congress rather than second guess whether the spending is actually for the general welfare.[234] 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).[235]

228. United States v. Butler, 297 U.S. 1, 85 (1936).

229. South Dakota v. Dole, 483 U.S. 203, 207 (1987).

230. *Id.* at 205.

231. *Id.* at 207–08.

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

233. The Spending Clause provides: "The Congress shall have Power . . . to pay the Debts and provide for the common Defence and general Welfare of the United States . . . ." U.S. CONST. art. I, § 8, cl. 1; *Dole*, 483 U.S. at 207.

234. *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 that general welfare means "the well-being of the nation as a whole" rather than a "particular region or locality." South Dakota v. Dole, 791 F.2d 628, 631 (8th Cir. 1986).

235. 42 U.S.C. § 1396-1 (2006).

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 list of 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.[236] 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.[237] According to *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."[238]

As an example for the pure funding statute model, consider the Medicaid Act, a more than forty-year-old law that Congress has modified yearly if not more frequently.[239] 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.[240] 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,

236. *See, e.g.*, Baker & Berman, *supra* note 35, at 464 (describing the general welfare prong as a "complete throwaway").

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

238. *Arlington*, 548 U.S. at 296.

239. 42 U.S.C. §§ 1396–1396v.

240. *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).

which passes the condition on to the states, most of which then 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.[241] 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.[242] 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.[243] But the clear notice prong of the *Dole* test only asks if the state understands the conditions on 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."[244]

Stated differently, the exercise of this particular right is much like the Sixth Amendment right to assistance of counsel,[245] 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.[246] Both the healthcare provider and the Medicaid enrollee are affected by the state's decision to accept the condition on 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.[247] That response would be misleading,

241. 42 U.S.C. §§ 1397ee(c)(1), 1397jj(a)(16).

242. 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. U.S. Dep't of Health & Human Servs., 289 F.3d 281, 297 (4th Cir. 2002).

243. South Dakota v. Dole 483 U.S. 203, 207 (1987). Justice Rehnquist wrote: "[O]bjectives 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.* (citation omitted).

244. *See* Tribe, *supra* note 104, at 333 ("[F]ailure to provide the needed aid at public expense amounts to forced alienation of the underlying right.").

245. *See* Alabama v. Shelton, 535 U.S. 654 (2002) (finding a fundamental right to appointment of counsel in misdemeanor cases where defendant is sentenced to a suspended period of incarceration); Gideon v. Wainwright, 372 U.S. 335 (1963) (finding a fundamental right to appointment of counsel in serious criminal cases).

246. *See* Kenneth Agran, *When Government Must Pay: Compensating Rights and the Constitution*, 22 CONST. COMMENT. 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).

247. 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

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

The clear notice requirement is also inadequate in the conscience clause funding statute context. 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 attached thereto. One of those conditions is the conscience clause funding statutes. The clear notice requirement of the *Dole* test does not protect the hospital, as it focuses on a state's acceptance of conditions on federal funds. Further, it does not protect individuals who seek treatment in the hospital and who have no control over the conditions on federal spending that may affect their care.[248]

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.'"[249] 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 would have given this prong some teeth.[250] 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. "Con-

sue at the time § 1983 was passed, perhaps revealing a larger attitude regarding legal entitlements and the individuals who benefit from such programs. *See* Huberfeld, *supra* note 37, at 433 n.103.

248. 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 (2006). If a woman is raped and present 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 and that is not an abortifacient). 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. 78,087 (Dec. 19, 2008).

249. South Dakota v. Dole, 483 U.S. 203, 207 (1987) (citing Massachusetts v. United States, 435 U.S. 444, 461 (1978) (plurality opinion)).

250. *See id.* at 212–18 (O'Connor, J., dissenting).

> gress 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."[251]

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.[252] 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 Justice O'Connor's dissent in *Dole*.[253] Thus, the germaneness analysis 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 . . . ."[254] 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: nearly half of all pregnancies in the United States are unintended, a third of all women aged twenty to twenty-four will terminate a pregnancy, and more than a fifth of all women will have an abortion by the end of their reproductive years.[255] Abortion is one of the most commonly performed medical procedures in the United States,[256] and it requires the assistance of a medical professional to safely perform the procedure either by medication or surgery.[257] Pure funding statutes such as the Hyde Amendment fail the germaneness test by denying to women legal, nonexperimental, and medically necessary assistance—a direct conflict with the goal of the Medicaid Act.[258] The

251. *Id.* at 215–16 (quoting Brief of the National Conference of State Legislatures et al. as Amici Curiae in Support of Petitioner, South Dakota v. Dole, 483 U.S. 203 (1987) (No. 86-260), 1987 WL 880310).

252. *See id.* at 216–17.

253. *See id.* at 215.

254. 42 U.S.C. § 1396 (2006).

255. *See* GUTTMACHER INST., FACTS ON INDUCED ABORTION IN AMERICA 1 (2008), http://www.guttmacher.org/pubs/fb_induced_abortion.pdf.

256. Rachel K. Jones et al., *Abortion in the United States: Incidence and Access to Services, 2005*, 40 PERSP. ON SEXUAL & REPROD. HEALTH 6, 6 (2008).

257. *See* NAT'L ABORTION FED'N, SAFETY OF ABORTION 2 (2006), http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/safety_of_abortion.pdf.

258. 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* 123 CONG. REC. 19,703–04 (1977). They failed to support 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.[259]

The reasonable relationship is 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.[260] Yet, this standard for analysis is flawed; for example, the Danforth Amendment is attached to Title X, an act that is intended to facilitate creation of "family planning facilities."[261] 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 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, are subject to the rules that protect healthcare providers who refuse to participate in abortion or sterilization.[262] The condition protects those with moral objections, not just religious objections, and allows everyone in the hospital to refuse to participate, including those who have no direct patient contact. This 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.[263]

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."[264] Chief Justice Rehnquist clarified this element by stat-

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 19,709.

259. 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. South Dakota v. Dole, 483 U.S. 203, 208 n.3 (1987).

260. *Id.* at 209.

261. 42 U.S.C. § 300 (2006).

262. *See supra* text accompanying notes 182–84.

263. *See* Baker & Berman, *supra* note 35, at 465–66.

264. *Dole*, 483 U.S. at 208.

ing that the spending power cannot be used "to induce the States to engage in activities that would themselves be unconstitutional."[265] 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.[266] The Court found that the Twenty-First Amendment did not pose an independent constitutional bar to the condition on highway funding.[267] 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.[268] 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.[269]

Dole's 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.[270] 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.

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 observed, 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.[271] Nevertheless,

265. *Id.* at 210.

266. *See id.* at 210–11.

267. *Id.* at 209–11.

268. *Id.* at 211–12.

269. 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 A. Farber, *Another View of the Quagmire: Unconstitutional Conditions and Contract Theory*, 33 FLA. ST. U. L. REV. 913, 914 (2006). *See generally* Mitchell N. Berman, *Coercion Without Baselines: Unconstitutional Conditions in Three Dimensions*, 90 GEO. L.J. 1 (2001); 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); Kathleen M. Sullivan, *Unconstitutional Conditions*, 102 HARV. L. REV. 1413 (1989).

270. Harris v. McRae, 488 U.S. 297, 326 (1980); Maher v. Roe, 432 U.S. 464, 474 (1976).

271. 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 govern-

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.[272] 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."[273] 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").[274]

Even so, the *Dole* Court appeared to find relevant the amount of federal funding provided and jeopardized for noncompliance; 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 fifty percent to eighty-three percent.[275] The more a state chooses to spend on its "deserving poor," the more the federal government must pay to match that state's expenditures.[276] Every state has participated in Medicaid since the early 1970s, and many of the poorest states are the richest recipients of federal Medicaid funds.[277] For example, Mississippi had the lowest median household income in 2007.[278] The most recent year for which complete data are available shows that in fiscal year 2006, Mississippi's federal match was

mental interest. This strict scrutiny test was applied in *Roe*, at least pre-viability. *See* Roe v. Wade, 410 U.S. 113, 155, 163 (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* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 874, 877–78 (1992). 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, 167–68 (2007).

272. *Dole*, 483 U.S. at 211. As stated by the majority: "[I]n some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" *Id.* (internal citations omitted).

273. *Id.* at 211–12.

274. *See, e.g.*, West Virginia v. U.S. Dep't of Health & Human Servs., 289 F.3d 281, 291–92 (4th Cir. 2002). For discussion of this case and its elaboration on the compulsion idea, see Huberfeld, *supra* note 240, at 458–62.

275. *See* 42 U.S.C. § 1396d(b) (2006) (delineating the formula for the Federal Medical Assistance Percentage, or FMAP, which determines the rate at which the federal government will match state funds).

276. *See id.*

277. *See* STEVENS & STEVENS, *supra* note 20, at 60–61.

278. Press Release, U.S. Census Bureau, 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.

seventy-six percent; the state received $3.17 for every dollar it spent on Medicaid (yet it still spent only $4144 per enrollee, lower than the national average of $4575).[279] In 2002, over half of all births in Mississippi were covered by Medicaid.[280] Compare Mississippi to New York, one of the wealthier states, which had an FMAP of fifty percent in 2006 and still spends significantly more per beneficiary ($7927), and covers abortion beyond the confines of the Hyde Amendment.[281]

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.[282] The examples 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.[283] 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.[284]

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.[285] Though federal courts have

279. Kaiser Family Foundation, Mississippi: Federal Matching Rate (FMAP) for Medicaid and Multiplier, http://www.statehealthfacts.org/profileind.jsp?ind=184&cat=4&rgn=26 (last visited Feb. 15, 2010); Kaiser Family Foundation, Mississippi: Medicaid Payments per Enrollee, FY2006, http://www.statehealthfacts.org/profileind.jsp?ind=183&cat=4&rgn=26 (last visited Feb. 15, 2010).

280. MEDICAID'S ROLE FOR WOMEN, *supra* note 115.

281. Kaiser Family Foundation, New York: Federal Matching Rate (FMAP) for Medicaid and Multiplier, http://www.statehealthfacts.org/profileind.jsp?ind=184&cat=4&rgn=34 (last visited Feb. 15, 2010); Kaiser Family Foundation, New York: Medicaid Payments per Enrollee, FY2006, http://www.statehealthfacts.org/profileind.jsp?ind=183&cat=4&rgn=34 (last visited Feb. 15, 2010).

282. NAT'L ABORTION FED'N, PUBLIC FUNDING FOR ABORTION: MEDICAID AND THE HYDE AMENDMENT 2 (2006), http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/public_funding.pdf.

283. MEDICAID'S ROLE FOR WOMEN, *supra* note 120 (noting that abortion rates are higher among low-income women and have been increasing since 1994, and that the procedure is becoming increasingly concentrated among poor women, including those on Medicaid).

284. *See supra* notes 58–67 and accompanying text. *See also* ABORTION IN THE U.S., *supra* note 133.

285. *See* Rosenbaum, *supra* note 6, at 6, 27–30 (explaining that the nation and the states cannot survive without Medicaid but that states also resent the financial burden it represents in their budgets).

often emphasized that states can refuse Medicaid funds if they dislike the conditions imposed on them,[286] this response is unrealistic; no matter how burdensome the condition, states have not ceased their Medicaid participation.[287] 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).[288] The Court in *McRae* and *Maher* indicated a belief that women could still access those services that the government refused to fund through Medicaid, but it is an illusion of choice given that Medicaid beneficiaries are extraordinarily poor and rely on Medicaid for all of their medical assistance.[289] Justice Blackmun recognized this fact in *Singleton v. Wulff*[290] and Justice Brennan so noted in his dissent in *Maher*,[291] and it is as true today as it was thirty years ago. 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,[292] and they help to highlight the missing piece in conditional spending. For example, Title X grant recipients create and maintain family planning clinics.[293] They tend to be local government actors and are more often nonprofit organizations.[294] 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.[295] Once an entity has accepted Title X funding, it would be extremely difficult to

286. *See* South Dakota v. Dole, 483 U.S. 203, 211–12 (1987).

287. 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, *supra* note 232, at 486–91 (discussing the constitutionality of the Clawback provision).

288. Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services., http://www.cms.hhs.gov/home/medicaid.asp (follow "Medicaid Eligibility" hyperlink) (last visited Feb. 15, 2010).

289. *See supra* notes 46–47, 67 and accompanying text.

290. Singleton v. Wulff, 428 U.S. 106, 117 (1976) ("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.").

291. Maher v. Roe, 432 U.S. at 464, 485–86 (1976) (Brennan, J., dissenting). 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: "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.* (quoting *Singleton*, 428 U.S. at 118–19 n.7).

292. CHRISTINA FOWLER, JULIA GABLE & JIANTONG WANG, RTI INT'L FAMILY PLANNING ANNUAL REPORT: 2007 NAT'L SUMMARY 7 (2008) (showing that fifty-five percent of Title X grants were awarded to state and local health departments, while the remaining forty-five percent were divided between nonprofit family planning agencies, independent clinics, and community health agencies); SONFIELD ET AL., *supra* note 134, at 9.

293. 42 U.S.C. § 300 (2006).

294. SONFIELD ET AL., *supra* note 134, at 9.

295. *See* Wilson, *supra* note 188, at 49.

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.[296] The assumption that the party accepting the conditions on spending can simply choose to reject the conditions seems 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.[297]

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.[298] This leniency seems inconsistent with the Rehnquist Court's revitalization of federalism and limitations on Commerce Clause power,[299] though it is consistent with the "greater includes the lesser" theory of conditional spending.[300] 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.[301]

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 endeavors to determine how impact on individuals can be reflected better in the conditional spending

296. *See supra* note 284 and accompanying text.

297. *See* Samuel R. Bagenstos, *Spending Clause Litigation in the Roberts Court*, 58 DUKE L.J. 345, 352 (2008). *See generally* Baker & Berman, *supra* note 35, at 485 (arguing that although the *Dole* test has been "toothless," it should not be completely abandoned).

298. *See* Baker, *supra* note 224, at 1988–89 (explaining how the Commerce Clause jurisprudence of the Rehnquist Court could coexist with the Spending Clause jurisprudence of the Court).

299. *See* United States v. Morrison, 529 U.S. 598, 608, 617–19 (2000); Printz v. United States, 521 U.S. 898, 924 (1997); United States v. Lopez, 514 U.S. 549, 567–68 (1995); New York v. United States, 505 U.S. 144, 161 (1992); South Dakota v. Dole, 483 U.S. 203, 218 (1987) (O'Connor, J., dissenting).

300. *See* Baker, *supra* note 232, at 1915 n.13.

301. *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) (arguing that the expansive Spending Clause power was minimally impacted by the Rehnquist Court's federalism revolution).

analysis. The Roberts Court thus far has limited individual rights and read statutory language narrowly,[302] admittedly a tricky combination for contemplating how conditions on spending can be evaluated with an eye toward protecting individuals.

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*.[303] The only canon that appears to cover the federal government-individual relationship is the unconstitutional conditions doctrine, which is incoherent.[304] This doctrine represents the Court's analysis of the federal government's ability to influence individual behavior through "spending, licensing, and employment."[305] 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.'"[306] 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."[307] 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.[308]

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.[309] 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

302. *See* Erwin Chemerinsky, *Turning Sharply to the Right*, 10 GREEN BAG 2d 423, 424 (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.

303. The 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, which is nonjusticiable. *See Dole*, 483 U.S. at 207.

304. *See* Farber, *supra* note 269, at 914, 926–31 (surveying the caselaw and the literature regarding unconstitutional conditions and noting that it is a "swamp").

305. Sunstein, *supra* note 32, at 593–94.

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

307. *Id.*

308. *See id.*; *see also supra* note 270 and accompanying text.

309. *See* Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy, 548 U.S. 291, 296 (2006); South Dakota v. Dole, 483 U.S. 203, 207 (1987).

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 assumes 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.[310] 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.[311] 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 (i.e., 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.[312] 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 Article indicates that *Dole* may be up to the task.[313] This would require the Court to scrutinize 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

310. *See supra* note 114–15 and accompanying text.

311. 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 269, at 935.

312. As Professor Farber observed, the Court has allowed many constitutional rights to become "alienable." *Id.* at 917–26.

313. *See supra* Part IV.B.

placed on landowners who wanted to build a home that would block public beach access.[314] 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 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.[315] 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,[316] 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.[317] South Dakota only jeopardized five percent 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.[318] On the other hand, in the case of Medicaid, Title X, and CHIP, failure to comply with conditions can result in complete withdrawal of funding.[319] 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.[320]

314. Nollan v. Cal. Coastal Comm'n, 483 U.S. 825, 828 (1987).

315. *Id.* at 837.

316. *Id.* at 846 (Brennan, J., dissenting).

317. *See* Farber, *supra* note 269, at 946. 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.

318. South Dakota v. Dole, 483 U.S. 203, 211 (1987).

319. 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, *supra* note 37, at 466. Of course, this would also create a potential violation of the False Claims Act. 31 U.S.C. § 3729 (2006).

320. 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 71, at 119.

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 efforts toward healthcare reform that include compromising women's reproductive rights.[321]

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. 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.

321. *See* George J. Annas, *Abortion Politics and Healthcare Reform*, 361 NEW ENG. J. MED. 2589, 2589–91 (2009), *available at* http://healthcarereform.nejm.org/?p=2463&query=TOC.