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Abortion: Judicial History and Legislative Response

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Summary

In 1973, the U.S. Supreme Court concluded in *Roe v. Wade* that the U.S. Constitution protects a woman's decision to terminate her pregnancy. In a companion decision, *Doe v. Bolton*, the Court found that a state may not unduly burden the exercise of that fundamental right with regulations that prohibit or substantially limit access to the procedure. Rather than settle the issue, the Court's rulings since *Roe* and *Doe* have continued to generate debate and have precipitated a variety of governmental actions at the national, state, and local levels designed either to nullify the rulings or limit their effect. These governmental regulations have, in turn, spawned further litigation in which resulting judicial refinements in the law have been no more successful in dampening the controversy.

Following *Roe*, the right identified in that case was affected by decisions such as *Webster v. Reproductive Health Services*, which gave greater leeway to the states to restrict abortion, and *Rust v. Sullivan*, which narrowed the scope of permissible abortion-related activities that are linked to federal funding. The Court's decision in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, which established the "undue burden" standard for determining whether abortion restrictions are permissible, gave Congress additional impetus to move on statutory responses to the abortion issue, such as the Freedom of Choice Act.

Legislation to prohibit a specific abortion procedure, the so-called "partial-birth" abortion procedure, was passed in the 108th Congress. The Partial-Birth Abortion Ban Act appears to be one of the only examples of Congress restricting the performance of a medical procedure. Legislation that would prohibit the performance of an abortion once the fetus reaches a specified gestational age has also been introduced in numerous Congresses.

Since *Roe*, Congress has attached abortion funding restrictions to various appropriations measures. The greatest focus has arguably been on restricting Medicaid abortions under the annual appropriations for the Department of Health and Human Services. This restriction is commonly referred to as the "Hyde Amendment" because of its original sponsor. Similar restrictions affect the appropriations for other federal agencies, including the Department of Justice, where federal funds may not be used to perform abortions in the federal prison system, except in cases of rape or if the life of the mother would be endangered. Hyde-type amendments also have an impact in the District of Columbia, where federal and local funds may not be used to perform abortions except in cases of rape or incest, or where the life of the mother would be endangered, and affect international organizations like the United Nations Population Fund, which receives funds through the annual Foreign Operations appropriations measure.

The debate over abortion also continued in the context of health reform. The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, includes provisions that address the coverage of abortion services by qualified health plans that are available through health benefit exchanges. The ACA's abortion provisions have been controversial, particularly with regard to the use of premium tax credits or cost-sharing subsidies to obtain health coverage that includes coverage for elective or nontherapeutic abortion services. Under the ACA, individuals who receive a premium tax credit or cost-sharing subsidy are permitted to select a qualified health plan that includes coverage for elective abortions, subject to funding segregation requirements that are imposed on both the plan issuer and the enrollees in such a plan.

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In 1973, the U.S. Supreme Court concluded in *Roe v. Wade* that the U.S. Constitution protects a woman's decision to terminate her pregnancy.[1] In a companion decision, *Doe v. Bolton*, the Court found that a state may not unduly burden the exercise of that fundamental right with regulations that prohibit or substantially limit access to the procedure.[2] Rather than settle the issue, the Court's rulings since *Roe* and *Doe* have continued to generate debate and have precipitated a variety of governmental actions at the national, state, and local levels designed either to nullify the rulings or limit their effect. These governmental regulations have, in turn, spawned further litigation in which resulting judicial refinements in the law have been no more successful in dampening the controversy.

Although the primary focus of this report is legislative action with respect to abortion, discussion of the various legislative proposals necessarily involves an examination of the leading Supreme Court decisions concerning a woman's right to choose.[3]

Judicial History

Roe v. Wade and *Doe v. Bolton*

In 1973, the Supreme Court issued its landmark abortion rulings in *Roe v. Wade* and *Doe v. Bolton*. In those cases, the Court found that Texas and Georgia statutes regulating abortion interfered to an unconstitutional extent with a woman's right to decide whether to terminate her pregnancy. The Texas statute forbade all abortions not necessary "for the purpose of saving the life of the mother."[4] The Georgia enactment permitted abortions only when continued pregnancy seriously threatened the woman's life or health, when the fetus was very likely to have severe birth defects, or when the pregnancy resulted from rape.[5] The Georgia statute also required that abortions be performed only at accredited hospitals and only after approval by a hospital committee and two consulting physicians.[6]

The Court's decisions were delivered by Justice Blackmun for himself and six other Justices. Justices White and Rehnquist dissented. The Court ruled that states may not categorically proscribe abortions by making their performance a crime, and that states may not make abortions unnecessarily difficult to obtain by prescribing elaborate procedural guidelines.[7] The constitutional basis for the decisions rested upon the conclusion that the Fourteenth Amendment right of personal privacy embraced a woman's decision whether to carry a pregnancy to term.[8] With regard to the scope of that privacy right, the Court stated that it includes "only personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty'" and bears some extension to activities related to marriage, procreation, contraception, family relationships,

[1] 410 U.S. 113 (1973).

[2] 410 U.S. 179 (1973).

[3] For additional discussion of the relevant case law, *see* CRS Report 95-724, *Abortion Law Development: A Brief Overview*, by Jon O. Shimabukuro.

[4] *See Roe*, 410 U.S. at 119.

[5] *See Doe*, 410 U.S. at 183.

[6] *Id* at 183-84.

[7] *Roe*, 410 U.S. at 164-65; *Doe*, 410 U.S. at 201.

[8] *See Roe*, 410 U.S. at 153.

child rearing, and education.[9] Such a right, the Court concluded, "is broad enough to encompass a woman's decision whether or not to terminate her pregnancy."[10]

With respect to protecting that right against state interference, the Court held that because the right of personal privacy is a fundamental right, only a "compelling State interest" could justify its limitation by a state.[11] Thus, while it recognized the legitimacy of the state interest in protecting maternal health and the preservation of the fetus's potential life, as well as the existence of a rational connection between these two interests and a state's anti-abortion law, the Court held these interests insufficient to justify an absolute ban on abortions.[12]

Instead, the Court emphasized the durational nature of pregnancy and found the state's interests to be sufficiently compelling to permit the curtailment or prohibition of abortion only during specified stages of pregnancy. The High Court concluded that until the end of the first trimester, an abortion is no more dangerous to maternal health than childbirth itself, and found that "[with] respect to the State's important and legitimate interest in the health of the mother, the 'compelling' point, in light of present medical knowledge, is at approximately the end of the first trimester."[13] Only after the first trimester did the state's interest in protecting maternal health provide a sufficient basis to justify state regulation of abortion, and then only to protect this interest.[14]

The "compelling" point with respect to the state's interest in the potential life of the fetus "is at viability."[15] Following viability, the state's interest permitted it to regulate and even proscribe an abortion except when necessary, in appropriate medical judgment, for the preservation of the life or health of the woman.[16] In summary, the Court's holding was grounded in this trimester framework analysis and the concept of fetal viability.[17]

In *Doe v. Bolton*, the Court extended *Roe* by warning that just as states may not prevent abortion by making its performance a crime, they may not make abortions unreasonably difficult to obtain by prescribing elaborate procedural barriers.[18] In *Doe*, the Court struck down Georgia's requirements that abortions be performed in licensed hospitals; that abortions be approved beforehand by a hospital committee; and that two physicians concur in the abortion decision.[19] The Court appeared to note, however, that this would not apply to a statute that protected the religious or moral beliefs of denominational hospitals and their employees.[20]

In *Roe*, the Court also dealt with the question of whether a fetus is a person under the Fourteenth Amendment and other provisions of the Constitution. The Court indicated that the Constitution never specifically defines the term "person," but added that in nearly all the sections where the

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[9] *Roe*, 410 U.S. at 152-53.

[10] *Id*. at 153.

[11] *Id*. at 155.

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

[13] *Id*. at 163.

[14] *Id*. at 163-64.

[15] *Id*.

[16] *Id*.

[17] *Id*. at 164-65. *See also id.* at 160 (defining the term "viable" as the point in fetal development when the fetus is "potentially able to live outside the mother's womb, albeit with artificial aid.").

[18] *Doe*, 410 U.S. at 201.

[19] *Id*. at 193-200.

[20] *Id*. at 197-98.

word "person" appears, "the use of the word is such that it has application only postnatally. None indicates, with any assurance, that it has any possible pre-natal application."[21] The Court emphasized that, given the fact that in the major part of the 19th century prevailing legal abortion practices were far freer than today, it was persuaded "that the word 'person', as used in the Fourteenth Amendment, does not include the unborn."[22]

The Court did not, however, resolve the question of when life actually begins. While noting the divergence of thinking on this issue, it instead articulated the legal concept of "viability," defined as the point at which the fetus is potentially able to live outside the womb, with or without artificial assistance.[23] Many other questions were also not addressed in *Roe* and *Doe*, but instead led to a wealth of post-*Roe* litigation.

Supreme Court Decisions After *Roe* and *Doe*

Following *Roe*, the Court examined a variety of federal and state requirements that addressed different concerns related to abortion: informed consent and mandatory waiting periods;[24] spousal and parental consent;[25] parental notice;[26] reporting requirements;[27] advertisement of abortion services;[28] abortions by nonphysicians;[29] locus of abortions;[30] viability, fetal testing, and disposal of fetal remains;[31] and "partial-birth" abortions.[32]

In *Rust v. Sullivan*, the Court upheld on both statutory and constitutional grounds the Department of Health and Human Services' Title X regulations restricting recipients of federal family planning funding from using federal funds to counsel women about abortion.[33] While *Rust* is probably better understood as a case involving First Amendment free speech rights rather than a challenge to the constitutionally guaranteed substantive right to abortion, the Court, following its earlier public funding cases (*Maher v. Roe*[34] and *Harris v. McRae*),[35] did conclude that a woman's

[21] *Roe*, 410 U.S. at 157.

[22] *Id*. at 158.

[23] *Id*. at 160.

[24] Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52 (1976); City of Akron v. Akron Ctr. for Reprod. Health, Inc., 462 U.S. 416 (1983).

[25] Planned Parenthood of Cent. Mo. v. Danforth, *supra;* Bellotti v. Baird, 443 U.S. 622 (1979); City of Akron v. Akron Ctr. for Reprod. Health, Inc., *supra*; Planned Parenthood Ass'n of Kan. City, Mo., Inc. v. Ashcroft, 462 U.S. 476 (1983).

[26] Bellotti v. Baird, *supra*; H. L. v. Matheson, 450 U.S. 398 (1981); Hartigan v. Zbaraz, 484 U.S. 171 (1987); Hodgson v. Minn., 497 U.S. 417 (1990); Ohio v. Akron Ctr. for Reprod. Health, 497 U.S. 502 (1990).

[27] Planned Parenthood of Cent. Mo. v. Danforth, *supra*; Planned Parenthood Ass'n of Kan. City, Mo., Inc. v. Ashcroft, *supra*.

[28] Bigelow v. Va., 421 U.S. 809 (1975).

[29] Conn. v. Menillo, 423 U.S. 9 (1975).

[30] City of Akron v. Akron Ctr. for Reprod. Health, Inc., *supra*; Planned Parenthood Association of Kan. City, Mo., Inc. v. Ashcroft, *supra*; Simopoulos v. Va., 462 U.S. 506 (1983).

[31] Planned Parenthood of Cent. Mo. v. Danforth, *supra*; Colautti v. Franklin, 439 U.S. 379 (1979); Planned Parenthood Association of Kan. City, Mo., Inc. v. Ashcroft, *supra*; City of Akron v. Akron Ctr. for Reprod. Health, Inc., *supra*.

[32] Stenberg v. Carhart, 530 U.S. 914 (2000); Gonzales v. Carhart, 550 U.S. 124 (2007).

[33] 500 U.S. 173 (1991).

[34] 432 U.S. 464 (1977) (upholding state regulation limiting Medicaid assistance to abortions certified as medically necessary).

[35] 448 U.S. 297 (1980) (upholding restrictions on the use of federal funds to perform abortions that are not medically necessary).

right to an abortion was not burdened by the Title X regulations. The Court reasoned that there was no constitutional violation because the government has no duty to subsidize an activity simply because it is constitutionally protected and because a woman is "in no worse position than if Congress had never enacted Title X."[36]

In addition to *Rust*, the Court decided several other noteworthy cases involving abortion following *Roe*. *Webster v. Reproductive Health Services*[37] and *Planned Parenthood of Southeastern Pennsylvania v. Casey*[38] illustrate the Court's shift from the type of constitutional analysis it articulated in *Roe*. These cases and other more recent cases, such as *Stenberg v. Carhart*[39] and *Ayotte v. Planned Parenthood of Northern New England*[40] have implications for future legislative action and how enactments will be judged by the courts in the years to come. *Webster*, *Casey*, and *Ayotte* are discussed in the subsequent sections of this report. A discussion of *Stenberg* is included in the "Partial-Birth Abortion" section of this report.

Webster

In *Webster v. Reproductive Health Services*, the Court upheld Missouri's restrictions on the use of public employees and facilities for the performance of abortions.[41] Although the Court did not overrule *Roe*, a plurality of Justices indicated that it was willing to apply a less stringent standard of review to state abortion regulations.[42] The plurality criticized the trimester framework established by *Roe*, noting that it "is hardly consistent with the notion of a Constitution cast in general terms[.]"[43] The plurality also questioned *Roe*'s identification of viability as the point at which a state could regulate abortion to protect potential life:

> [W]e do not see why the State's interest in protecting potential human life should come into existence only at the point of viability, and that there should therefore be a rigid line allowing state regulation after viability but prohibiting it before viability.[44]

Webster recognized that state legislatures retain considerable discretion to pass abortion regulations, and acknowledged the likelihood that such regulations would probably pass constitutional muster in the future.[45] However, because *Webster* did not affect private doctors' offices or clinics, the ruling was arguably narrow in scope. Nevertheless, *Webster* set the stage for the Court's 1992 decision in *Casey*, where a real shift in direction was pronounced.

Casey

Webster and *Rust* energized legislative activity at the federal and state levels. Some of the state legislative proposals that became law were later challenged in the courts.[46] The constitutionality

[36] *Rust*, 500 U.S. at 203.

[37] 492 U.S. 490 (1989).

[38] 505 U.S. 833 (1992).

[39] 530 U.S. 914 (2000).

[40] 546 U.S. 320 (2006).

[41] 492 U.S. 490 (1989).

[42] *Id.* at 516-22.

[43] *Id*. at 518.

[44] *Id*. at 519.

[45] *Id*. at 520-21.

[46] *See, e.g.*, Sojorner v. Roemer, 772 F.Supp. 930 (E.D. La. 1991) (invalidating Louisiana abortion law).

of Pennsylvania's Abortion Control Act was examined by the Court in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.[47] In *Casey*, a plurality of the Court rejected the trimester framework established in *Roe*, explaining that "in its formulation [the framework] misconceives the pregnant woman's interest ... and in practice it undervalues the State's interest in potential life[.]"[48] In its place, the plurality adopted a new "undue burden" standard, maintaining that this standard recognized the need to reconcile the government's interest in potential life with a woman's right to decide to terminate her pregnancy.[49] While *Roe* generally restricted the regulation of abortion during the first trimester, *Casey* emphasized that not all of the burdens imposed by an abortion regulation were likely to be undue. Under *Casey*, an undue burden exists if the purpose or effect of an abortion regulation is "to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability."[50]

In adopting the new undue burden standard, *Casey* nonetheless reaffirmed the essential holding of *Roe*, which the plurality described as having three parts.[51] First, a woman has a right to choose to have an abortion prior to viability without undue interference from the state. Second, the state has a right to restrict abortions after viability so long as the regulation provides an exception for pregnancies that endanger a woman's life or health. Third, the state has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus.

After applying the undue burden standard in *Casey*, four provisions of the Pennsylvania law were upheld. The law's 24-hour waiting period requirement, its informed consent provision, its parental consent provision, and its recordkeeping and reporting requirements were found to not impose an undue burden.[52] While the plurality acknowledged that these requirements, notably the 24-hour waiting period, could delay the procedure or make an abortion more expensive, it nevertheless concluded that they did not impose an undue burden. Moreover, the plurality emphasized that "under the undue burden standard a State is permitted to enact persuasive measures which favor childbirth over abortion even if those measures do not further a health interest."[53]

The law's spousal notification provision, which required a married woman to tell her husband of her intention to have an abortion, did not survive the undue burden analysis.[54] A majority of the Court maintained that the requirement imposed an undue burden because it could result in spousal abuse and discourage a woman from seeking an abortion: "The spousal notification requirement is thus likely to prevent a significant number of women from obtaining an abortion. It does not merely make abortions a little more difficult or expensive to obtain; for many women, it will impose a substantial obstacle."[55]

The plurality's decision in *Casey* was significant because the new standard of review appeared to allow more state restrictions to pass constitutional muster. In addition, the plurality maintained that the state's interest in protecting the potentiality of human life extended throughout the course

[47] 505 U.S. 833 (1992).

[48] *Id*. at 873.

[49] *Id*. at 876.

[50] *Id*. at 877.

[51] *Id*. at 846.

[52] *Id*. at 881-901.

[53] *Id*. at 886.

[54] *Id*. at 887-98.

[55] *Id*. at 893-94.

of the pregnancy.[56] Thus, the state could regulate, even to the point of favoring childbirth over abortion, from the outset. Under *Roe*, which utilized the trimester framework, a woman's decision to terminate her pregnancy was reached in consultation with her doctor with virtually no state involvement during the first trimester of pregnancy.

In addition, under *Roe*, abortion was a "fundamental right" that could not be restricted by the state except to serve a "compelling" state interest. *Roe*'s strict scrutiny standard of review resulted in most state regulations being invalidated during the first two trimesters of pregnancy. The "undue burden" standard allowed greater regulation during that period. This is evident from the fact that the *Casey* Court overruled, in part, two of its earlier decisions which had followed *Roe*: *City of Akron v. Akron Center for Reproductive Health*[57] and *Thornburgh v. American College of Obstetricians and Gynecologists*.[58] In these cases, the Court, applying strict scrutiny, struck down 24-hour waiting periods and informed consent provisions; whereas in *Casey*, applying the undue burden standard, the Court upheld similar provisions.

Casey had its greatest immediate effect on women in the state of Pennsylvania; however, its reasoning prompted other states to pass similar restrictions that would withstand challenge under the "undue burden" standard.[59]

Partial-Birth Abortion

On June 28, 2000, the Court decided *Stenberg v. Carhart*, its first substantive abortion case since *Casey*.[60] In *Stenberg*, the Court determined that a Nebraska statute that prohibited the performance of so-called "partial-birth" abortions was unconstitutional because it failed to include an exception to protect the health of the mother and because the language defining the prohibited procedure was too vague.[61] In affirming the decision of the U.S. Court of Appeals for the Eighth Circuit, the Court agreed that the language of the Nebraska statute could be interpreted to prohibit not just the dilation and extraction (D&X) procedure that prolife advocates oppose, but the standard dilation and evacuation (D&E) procedure that is the most common abortion procedure during the second trimester of pregnancy.[62] The Court maintained that the statute was likely to prompt those who perform the D&E procedure to stop because of fear of prosecution and conviction.[63] The result would be the imposition of an "undue burden" on a woman's ability to have an abortion.

After several attempts to pass federal legislation that would prohibit the performance of partial-birth abortions, Congress passed the Partial-Birth Abortion Ban Act of 2003 during the 108th Congress.[64] The measure was signed by President George W. Bush on November 5, 2003. In general, the act prohibits physicians from performing a partial-birth abortion except when it is

[56] *Id*. at 872-73.

[57] 462 U.S. 416 (1983).

[58] 476 U.S. 747 (1986).

[59] *See, e.g.*, Mazurek v. Armstrong, 520 U.S. 968 (1997) (upholding Montana statute restricting the performance of abortions to licensed physicians).

[60] 530 U.S. 914 (2000).

[61] *See also* CRS Report RL30415, *Partial-Birth Abortion: Recent Developments in the Law*, by Jon O. Shimabukuro (available to congressional clients upon request).

[62] *Stenberg*, 530 U.S. at 939.

[63] *Id*. at 945.

[64] Pub. L. No. 108-105, 117 Stat. 1201 (2003).

necessary to save the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself.[65] Physicians who violate the act are subject to a fine, imprisonment for not more than two years, or both.[66]

Despite the Court's holding in *Stenberg* and past decisions concluding that restrictions on abortion must allow for the performance of the procedure when it is necessary to protect the health of the mother, the Partial-Birth Abortion Ban Act of 2003 does not include such an exception. In his introductory statement for the act, Senator Rick Santorum discussed the measure's lack of a health exception.[67] He maintained that an exception is not necessary because of the risks associated with partial-birth abortions. Senator Santorum insisted that congressional hearings and expert testimony demonstrate "that a partial birth abortion is never necessary to preserve the health of the mother, poses significant health risks to the woman, and is outside the standard of medical care."[68]

Within two days of the act's signing, federal courts in Nebraska, California, and New York blocked its enforcement.[69] On April 18, 2007, the Court upheld the Partial-Birth Abortion Ban Act of 2003, finding that, as a facial matter, it is not unconstitutionally vague and does not impose an undue burden on a woman's right to terminate her pregnancy.[70] In *Gonzales v. Carhart*, the Court distinguished the federal statute from the Nebraska law at issue in *Stenberg*.[71] According to the Court, the federal statute is not unconstitutionally vague because it provides doctors with a reasonable opportunity to know what conduct is prohibited.[72] Unlike the Nebraska law, which prohibited the delivery of a "substantial portion" of the fetus, the federal statute includes "anatomical landmarks" that identify when an abortion procedure will be subject to the act's prohibitions.[73] The Court noted: "[I]f an abortion procedure does not involve the delivery of a living fetus to one of these 'anatomical landmarks'—where, depending on the presentation, either the fetal head or the fetal trunk past the navel is outside the body of the mother—the prohibitions of the Act do not apply."[74]

The Court also maintained that the inclusion of a scienter or knowledge requirement in the federal statute alleviates any vagueness concerns. Because the act applies only when a doctor "deliberately and intentionally" delivers the fetus to an anatomical landmark, the Court concluded that a doctor performing the D&E procedure would not face criminal liability if a fetus is delivered beyond the prohibited points by mistake.[75] The Court observed: "The scienter requirements narrow the scope of the Act's prohibition and limit prosecutorial discretion."[76]

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[65] 18 U.S.C. § 1531(a).

[66] *Id*.

[67] 149 Cong. Rec. S2523 (daily ed. February 14, 2003) (statement of Senator Santorum).

[68] *Id*.

[69] Carhart v. Ashcroft, 287 F.Supp.2d 1015 (D. Neb. 2003); Planned Parenthood Fed'n of America v. Ashcroft, No. C 03-4872 (N.D. Cal. Nov. 6, 2003); Nat'l Abortion Fed'n v. Ashcroft, 287 F.Supp.2d 525 (S.D.N.Y. 2003).

[70] 550 U.S. 124 (2007). Unlike "as-applied" challenges, which consider the validity of a statute as applied to a particular plaintiff, "facial" challenges seek to invalidate a statute in all of its applications.

[71] *Id*. at 141.

[72] *Id*. at 149.

[73] *See* 18 U.S.C. § 1531(b)(1)(A).

[74] *Gonzales*, 550 U.S. at 148.

[75] *Id*.

[76] *Id*. at 150.

In reaching its conclusion that the Partial-Birth Abortion Ban Act of 2003 does not impose an undue burden on a woman's right to terminate her pregnancy, the Court considered whether the federal statute is overbroad, prohibiting both the D&X and D&E procedures. The Court also considered the statute's lack of a health exception.

Relying on the plain language of the act, the Court determined that the federal statute could not be interpreted to encompass the D&E procedure. The Court maintained that the D&E procedure involves the removal of the fetus in pieces.[77] In contrast, the federal statute uses the phrase "delivers a living fetus."[78] The Court stated: "D&E does not involve the delivery of a fetus because it requires the removal of fetal parts that are ripped from the fetus as they are pulled through the cervix."[79] The Court also identified the act's specific requirement of an "overt act" that kills the fetus as evidence of its inapplicability to the D&E procedure. The Court indicated: "This distinction matters because, unlike [D&X], standard D&E does not involve a delivery followed by a fatal act."[80] Because the act was found not to prohibit the D&E procedure, the Court concluded that it is not overbroad and does not impose an undue burden a woman's ability to terminate her pregnancy.

According to the Court, the absence of a health exception also did not result in an undue burden. Citing *Ayotte v. Planned Parenthood of Northern New England*,[81] its 2006 decision involving New Hampshire's parental notification law (discussed below), the Court noted that a health exception would be required if the act subjected women to significant health risks.[82] However, acknowledging medical disagreement about the act's requirements ever imposing significant health risks on women, the Court maintained that "the question becomes whether the Act can stand when this medical uncertainty persists."[83] Reviewing its past decisions, the Court indicated that it has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty.[84] The Court concluded that this medical uncertainty provides a sufficient basis to conclude in a facial challenge of the statute that it does not impose an undue burden.[85]

Although the Court upheld the Partial-Birth Abortion Ban Act of 2003 without a health exception, it acknowledged that there may be "discrete and well-defined instances" where the prohibited procedure "must be used."[86] However, the Court indicated that exceptions to the act should be considered in as-applied challenges brought by individual plaintiffs: "In an as-applied challenge the nature of the medical risk can be better quantified and balanced than in a facial attack."[87]

Justice Ginsburg authored the dissent in *Gonzales*.[88] She was joined by Justices Stevens, Souter, and Breyer. Describing the Court's decision as "alarming," Justice Ginsburg questioned

[77] *Id*. at 152.

[78] 18 U.S.C. § 1531(b)(1)(A).

[79] *Gonzales*, 550 U.S. at 152.

[80] *Id*. at 153.

[81] 546 U.S. 320 (2006).

[82] *Gonzales*, 550 U.S. at 161.

[83] *Id*. at 163.

[84] *Id*.

[85] *Id*. at 164.

[86] *Id*. at 167.

[87] *Id*.

[88] *Id*. at 169.

upholding the federal statute when the relevant procedure has been found to be appropriate in certain cases.[89] Citing expert testimony that had been introduced, Justice Ginsburg maintained that the prohibited procedure has safety advantages for women with certain medical conditions, including bleeding disorders and heart disease.[90]

Justice Ginsburg also criticized the Court's decision to uphold the statute without a health exception. Justice Ginsburg declared: "Not only does it defy the Court's longstanding precedent affirming the necessity of a health exception, with no carve-out for circumstances of medical uncertainty ... it gives short shrift to the records before us, carefully canvassed by the District Courts."[91] Moreover, according to Justice Ginsburg, the refusal to invalidate the Partial-Birth Abortion Ban Act of 2003 on facial grounds was "perplexing" in light of the Court's decision in *Stenberg*.[92] Justice Ginsburg noted: "[I]n materially identical circumstances we held that a statute lacking a health exception was unconstitutional on its face."[93]

Ayotte

In *Ayotte v. Planned Parenthood of Northern New England*, the Court concluded that a wholesale invalidation of New Hampshire's Parental Notification Prior to Abortion Act was inappropriate.[94] Finding that only a few applications of the act raised constitutional concerns, the Court remanded the case to the lower courts to render narrower declaratory and injunctive relief.

The New Hampshire law at issue in *Ayotte* prohibited physicians from performing an abortion on a pregnant minor or a woman for whom a guardian or conservator was appointed until 48 hours after written notice was delivered to at least one parent or guardian.[95] The notification requirement could be waived under certain specified circumstances. For example, notification was not required if the attending abortion provider certified that an abortion was necessary to prevent the woman's death and there was insufficient time to provide the required notice.[96]

Planned Parenthood of Northern New England and several other abortion providers challenged the New Hampshire statute on the grounds that it did not include an explicit waiver that would allow an abortion to be performed to protect the health of the woman.[97] The U.S. Court of Appeals for the First Circuit invalidated the statute in its entirety on that basis.[98] The First Circuit also maintained that the act's life exception was impermissibly vague and forced physicians to gamble with their patients' lives by preventing them from performing an abortion without notification until they were certain that death was imminent.[99]

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[89] *Id*. at 170.

[90] *Id*. at 177.

[91] *Id*. at 179.

[92] *Id*. at 187.

[93] *Id*.

[94] 546 U.S. 320 (2006).

[95] *See id*. at 323-24.

[96] *Id*. at 324.

[97] *Id*. at 324-25.

[98] 390 F.3d 53 (1st Cir. 2004).

[99] *Id*. at 63.

Declining to revisit its prior abortion decisions, the Court insisted that *Ayotte* presented a question of remedy.[100] Maintaining that the act would be unconstitutional only in medical emergencies, the Court determined that a more narrow remedy, rather than the wholesale invalidation of the act, was appropriate:

> Generally speaking, when confronting a constitutional flaw in a statute, we try to limit the solution to the problem. We prefer, for example, to enjoin only the unconstitutional applications of a statute while leaving other applications in force ... or to sever its problematic portions while leaving the remainder intact.[101]

The Court identified three interrelated principles that inform its approach to remedies.[102] First, the Court tries not to nullify more of a legislature's work than is necessary because a ruling of unconstitutionality frustrates the intent of the elected representatives of the people.[103]

Second, the Court restrains itself from rewriting a state law to conform to constitutional requirements, even as it attempts to salvage the law.[104] The Court explained that its constitutional mandate and institutional competence are limited, noting that "making distinctions in a murky constitutional context" may involve a far more serious invasion of the legislative domain than the Court ought to take.[105]

Third, the touchstone for any decision about remedy is legislative intent; that is, a court cannot use its remedial powers to circumvent the intent of the legislature.[106] The Court observed that "[a]fter finding an application or portion of a statute unconstitutional, we must next ask: Would the legislature have preferred what is left of its statute to no statute at all?"[107]

On remand, the lower courts were expected to determine the intent of the New Hampshire legislature when it enacted the parental notification statute. Although the state argued that the measure's severability clause illustrated the legislature's understanding that the act should continue in force even if certain provisions were invalidated, the respondents insisted that New Hampshire legislators actually preferred no statute rather than one that would be enjoined in the manner described by the Court.[108] On February 1, 2007, a federal district court in New Hampshire entered a procedural order that stayed consideration of the case while a bill to repeal the Parental Notification Prior to Abortion Act was pending in the state legislature.[109] The act was subsequently repealed by the legislature, effective June 29, 2007.[110]

Ayotte illustrated the Court's willingness to invalidate an abortion regulation only as applied in certain circumstances. While it is not uncommon for federal courts to save a statute from invalidation by severing unconstitutional provisions, they have generally limited this practice to

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[100] *Ayotte*, 546 U.S. at 327.

[101] *Id*. at 328-29.

[102] *Id*. at 329.

[103] *Id*.

[104] *Id*.

[105] *Id*. at 330.

[106] *Id*.

[107] *Id*.

[108] *Id*. at 331.

[109] *See* Planned Parenthood of N. New England v. Ayotte, 571 F.Supp.2d 265 (D. N.H. 2008).

[110] *Abortion Law to Notify Parents Repealed*, Chicago Tribune, June 30, 2007, at 7.

federal statutes. Observers noted that the Court's opinion represented an expansion of federal judicial power over the states.[111]

Whole Woman's Health

In *Whole Woman's Health v. Hellerstedt*, the Court invalidated two Texas requirements that applied to abortion providers and physicians who perform abortions.[112] Under a Texas law enacted in 2013, a physician who performs or induces an abortion was required to have admitting privileges at a hospital within 30 miles from the location where the abortion was performed or induced.[113] In general, admitting privileges allow a physician to transfer a patient to a hospital if complications arise in the course of providing treatment. The Texas law also required an abortion facility to satisfy the same standards as an ambulatory surgical center (ASC).[114] These standards address architectural and other structural matters, as well as operational concerns, such as staffing and medical records systems. Supporters of the Texas law maintained that the requirements would guarantee a higher level of care for women seeking abortions. Opponents, however, characterized the requirements as unnecessary and costly, and argued that they would make it more difficult for abortion facilities to operate.

In a 5-3 decision, the Court rejected the procedural and constitutional grounds that were articulated by the U.S. Court of Appeals for the Fifth Circuit to uphold the requirements. Writing for the majority in *Whole Woman's Health*, Justice Breyer concluded that *res judicata* did not bar facial challenges to either the admitting privileges requirement or the ASC requirement.[115] In applying the undue burden standard, Justice Breyer maintained that courts should place considerable weight on the evidence and arguments presented in judicial proceedings when they consider the constitutionality of abortion regulations.[116] Justice Breyer also noted that the undue burden standard requires courts to consider "the burdens a law imposes on abortion access together with the benefits those laws confer."[117]

The *Whole Woman's Health* Court referred heavily to the evidence collected by the district court in its examination of the admitting privileges and ASC requirements. With regard to the admitting privileges requirement, the Court cited the low complication rates for first- and second-trimester abortions, and expert testimony that complications during the abortion procedure rarely require hospital admission.[118] Based on this and similar evidence, the Court disputed the state's assertion that the purpose of the admitting privileges requirement was to ensure easy access to a hospital should complications arise. The Court emphasized that "there was no significant health-related problem that the new law helped to cure."[119] Citing other evidence concerning the closure of abortion facilities as a result of the admitting privileges requirement and the increased driving distances experienced by women of reproductive age because of the closures, the Court

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[111] *See, e.g.*, Jack M. Balkin, *The Ayotte Compromise*, Balkinization (Jan. 18, 2006, 12:48 PM), https://balkin.blogspot.com/2006/01/ayotte-compromise.html.

[112] 136 S.Ct. 2292 (2016).

[113] *See id*. at 2300.

[114] *Id*.

[115] *Id*. at 2309.

[116] *Id*. at 2310.

[117] *Id*. at 2309.

[118] *Id*. at 2311.

[119] *Id*.

maintained: "[T]he record evidence indicates that the admitting-privileges requirement places a 'substantial obstacle in the path of a woman's choice.'"[120]

The Court again referred to the record evidence to conclude that the ASC requirement imposed an undue burden on the availability of abortion. Noting that the record supports the conclusion that the ASC requirement "does not benefit patients and is not necessary," the Court also cited the closure of facilities and the cost to comply with the requirement as evidence that the requirement posed a substantial obstacle for women seeking abortions.[121] While Texas argued that the clinics remaining after implementation of the ASC requirement could expand to accommodate all of the women seeking an abortion, the Court indicated that "requiring seven or eight clinics to serve five times their usual number of patients does indeed represent an undue burden on abortion access."[122]

The majority's focus on the record evidence, and a court's consideration of that evidence in balancing the burdens imposed by an abortion regulation against its benefits, is noteworthy for providing clarification of the undue burden standard. Although the *Casey* Court did examine the evidence collected by the district court with respect to Pennsylvania's spousal notification requirement, and was persuaded by it, the Fifth Circuit discounted similar evidence collected by the district court in its consideration of the two requirements.[123] In *Whole Woman's Health*, the Court maintained that the Fifth Circuit's approach did "not match the standard that this Court laid out in *Casey* ..."[124]

Public Funding of Abortions

After the Supreme Court's decisions in *Roe* and *Doe*, some of the first federal legislative responses involved restrictions on the use of federal money to pay for abortions. In 1976, Representative Henry J. Hyde offered an amendment to the Departments of Labor and Health, Education, and Welfare, Appropriation Act, 1977, that restricted the use of appropriated funds to pay for abortions provided through the Medicaid program.[125] Almost immediately, the so-called Hyde Amendment and similar restrictions were challenged in the courts. Two categories of public funding cases have been heard and decided by the Supreme Court: those involving (1) funding restrictions for nontherapeutic (elective) abortions; and (2) funding limitations for therapeutic (medically necessary) abortions.

[120] *Id*. at 2312 (quoting *Casey*, 505 U.S. at 877).

[121] *Id*. at 2315.

[122] *Id*. at 2318.

[123] *See* Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott, 748 F.3d 583, 598 (5th Cir. 2014) (stating that the district court's finding that "there will be abortion clinics that will close" was too vague); Whole Woman's Health v. Cole, 790 F.3d 563, 590 (5th Cir. 2015) (finding the district court's determination that the ASCs that perform abortions could not accommodate patients affected by the closure of non-ASC facilities was "unsupported by evidence" and "clearly erroneous").

[124] *Whole Woman's Heath*, 136 S.Ct. at 2310.

[125] *See* Pub. L. No. 94-439, § 209, 90 Stat. 1418, 1434 (1976) ("None of the funds contained in this Act shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term.").

The 1977 Trilogy—Restrictions on Public Funding of Nontherapeutic or Elective Abortions

The Supreme Court, in three related decisions, ruled that the states have neither a statutory nor a constitutional obligation to fund elective abortions or provide access to public facilities for such abortions.[126]

In *Beal v. Doe*, the Court held that nothing in the language or legislative history of Title XIX of the Social Security Act (Medicaid) requires a participating state to fund every medical procedure falling within the delineated categories of medical care.[127] The Court ruled that it was not inconsistent with the act's goals to refuse to fund unnecessary medical services. However, the Court also indicated that Title XIX left a state free to include coverage for nontherapeutic abortions should it choose to do so.[128] Similarly, in *Maher v. Roe*, the Court held that the Equal Protection Clause does not require a state participating in the Medicaid program to pay expenses incident to nontherapeutic abortions simply because the state has made a policy choice to pay expenses incident to childbirth.[129] More particularly, Connecticut's policy of favoring childbirth over abortion was held not to impinge upon the fundamental right of privacy recognized in *Roe*, which protects a woman from undue interference in her decision to terminate a pregnancy.[130] Finally, in *Poelker v. Doe*, the Court upheld a municipal regulation that denied indigent pregnant women nontherapeutic abortions at public hospitals.[131] The Court also held that staffing those hospitals with personnel opposed to the performance of abortions did not violate the Equal Protection Clause of the Constitution.[132] *Poelker*, however, did not deal with the question of private hospitals and their authority to prohibit abortion services.

Public Funding of Therapeutic or Medically Necessary Abortions

The 1977 Supreme Court decisions left open the question of whether the Hyde Amendment and similar state laws could validly prohibit the governmental funding of therapeutic abortions. In *Harris v. McRae*, the Court ruled 5-4 that the Hyde Amendment's abortion funding restrictions were constitutional.[133] The majority found that the Hyde Amendment did not violate the due process or equal protection guarantees of the Fifth Amendment or the Establishment Clause of the First Amendment. The Court also upheld the right of a state participating in the Medicaid program to fund only those medically necessary abortions for which it received federal reimbursement.[134] In *Williams v. Zbaraz*, a companion case raising similar issues, the Court held that an Illinois statutory funding restriction that was comparable to the Hyde Amendment also did not contravene the constitutional restrictions of the Equal Protection Clause of the Fourteenth Amendment.[135] The Court's rulings in *McRae* and *Zbaraz* indicate that there is no statutory or

[126] Beal v. Doe, 432 U.S. 438 (1977); Maher v. Roe, 432 U.S. 464 (1977); Poelker v. Doe, 432 U.S. 519 (1977).

[127] *Beal*, 432 U.S. at 447.

[128] *Id*.

[129] *Maher*, 432 U.S. at 480.

[130] *Id*. at 474.

[131] *Poelker*, 432 U.S. at 521.

[132] *Id*.

[133] 448 U.S. 297 (1980).

[134] *Id*. at 309-10.

[135] 448 U.S. 358 (1980).

constitutional obligation of the federal government or the states to fund medically necessary abortions.

Legislative History

Rather than settle the issue, the Court's decisions in *Roe* and *Doe* prompted debate and a variety of governmental actions at the national, state, and local levels to limit their effect. Congress continues to be a forum for proposed legislation and constitutional amendments aimed at limiting or prohibiting the practice of abortion. This section examines the history of the federal legislative response to the abortion issue.

Prior to the Court's decision in *Roe*, relatively few bills involving abortion were introduced in either the House or the Senate. Since 1973, however, more than 1,000 separate legislative proposals have been introduced. The wide disparity in these statistics illustrates the impetus that the Court's 1973 decisions gave to congressional action. Most of these proposals have sought to restrict the availability of abortions. Some measures, however, have been introduced to better secure the right to terminate a pregnancy. The Freedom of Choice Act, for example, attempted to codify *Roe* and was introduced in several Congresses.[136] The Freedom of Access to Clinic Entrances Act of 1994 made it a federal crime to use force, or the threat of force, to intimidate abortion clinic workers or women seeking abortions.[137]

Constitutional Amendments

Proponents of more restrictive abortion legislation have employed a variety of legislative initiatives to achieve this end, with varying degrees of success. Initially, legislators focused their efforts on the passage of a constitutional amendment that would overrule the Supreme Court's decision in *Roe*. This course, however, proved to be problematic.

Following *Roe*, a series of constitutional amendments were introduced in an attempt to overrule the Court's decision.[138] To date, however, no constitutional amendment has been passed in either the House or the Senate. Moreover, for several years, proponents of a constitutional amendment had difficulty getting the measures reported out of committee. Interest in the constitutional approach peaked in the 94th Congress, when nearly 80 amendments were introduced. By the 98th Congress, the number had significantly declined. It was during this time that the Senate brought to the floor the only constitutional amendment on abortion that has ever been debated and voted on in either chamber.

S.J.Res. 3 was introduced during the 98th Congress.[139] Subcommittee hearings were held, and the full Judiciary Committee voted (9-9) to send the amendment to the Senate floor without recommendation. As reported, S.J.Res. 3 included a subcommittee amendment that eliminated the enforcement language and declared simply, "A right to abortion is not secured by this Constitution."[140] By adopting this proposal, the subcommittee established its intent to remove

[136] *See, e.g.*, S. 1173, 110th Cong. (2007).

[137] 18 U.S.C. 248 note.

[138] *See e.g.*, H.J. Res. 527, 94th Cong. (1975).

[139] S.J.Res. 3, 98th Cong. (1983).

[140] *Id*.

federal institutions from the policymaking process with respect to abortion and reinstate state authorities as the ultimate decisionmakers.

S.J.Res. 3 was considered in the Senate on June 27 and 28, 1983. On June 28, 1983, S.J.Res. 3 was defeated (50-49), not having obtained the two-thirds vote necessary for a constitutional amendment.[141]

Statutory Provisions

Bills That Seek to Prohibit the Right to Abortion by Statute

As an alternative to a constitutional amendment to prohibit or limit the practice of abortion, opponents of the procedure have introduced a variety of bills designed to accomplish the same objective without resorting to the complex process of amending the Constitution. Authority for such action is said to emanate from Section 5 of the Fourteenth Amendment, which empowers Congress to enforce the due process and equal protection guarantees of the amendment "by appropriate legislation."[142] For example, S. 158, introduced during the 97th Congress, would have declared as a congressional finding of fact that human life begins at conception, and would, it was contended by its sponsors, allow states to enact laws protecting human life, including fetuses.[143] Hearings on the bill were marked by controversy over the constitutionality of the declaration that human life begins at conception and over the withdrawal of lower federal court jurisdiction over suits challenging state laws enacted pursuant to federal legislation.[144] A modified version of S. 158 was approved in subcommittee, but that bill, S. 1741, was not further considered in the 97th Congress.[145]

Hyde-Type Amendments to Appropriations Measures

As an alternative to the unsuccessful attempts to prohibit abortion outright, opponents of abortion sought to ban the use of federal funds to pay for the performance of the procedure. Because most federally funded abortions were reimbursed under Medicaid, they focused their efforts primarily on that program.

The Medicaid program was established in 1965 to fund medical care for indigent persons through a federal-state cost-sharing arrangement.[146] Abortions were not initially covered under the program. During the Nixon Administration, however, the Department of Health, Education, and Welfare decided to reimburse states for the funds used to provide abortions to poor women. This policy decision was influenced by the Supreme Court's decision in *Roe*, which, in addition to decriminalizing abortion, was seen as legitimizing the status of abortion as a medical procedure for the purposes of the Medicaid program.

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[141] For a review of the full debate on S.J.Res. 3, *see* 129 Cong. Rec. S9076 *et seq*. (daily ed. June 27, 1983); 129 Cong. Rec. S9265 *et seq*. (daily ed. June 28, 1983).

[142] U.S. Const. amend. XIV, § 5.

[143] S. 158, 97th Cong. (1981).

[144] *The Human Life Bill: Hearings Before the Senate Subcommittee on Separation of Powers*, 97th Cong. (1982).

[145] S. 1741, 97th Cong. (1981).

[146] Pub. L. No. 89-97, tit. I, § 121(a), 79 Stat. 286, 344 (1965).

Since *Roe*, Congress has attached abortion funding restrictions to several other appropriations bills. Although the Foreign Assistance Act of 1973 included the first of such restrictions,[147] the greatest focus has arguably been on the Hyde Amendment, which generally restricts Medicaid abortions under the annual appropriations for the Department of Health and Human Services (HHS).[148]

Since its initial introduction in 1976, the Hyde Amendment has sometimes been reworded to include exceptions for pregnancies that are the result of rape or incest, or abortions that are sought to prevent long-lasting physical health damage to the mother. Until the early 1990s, however, the language was generally identical to the original enactment, allowing only an exception to preserve the life of the mother.[149] In 1993, during the first year of the Clinton Administration, coverage under the Hyde Amendment was expanded to again include cases of rape and incest.[150] Efforts to restore the original language (providing only for the life of the woman exception) failed in the 104th Congress.

Beginning in 1978, Hyde-type abortion limitations were added to the Department of Defense appropriations measures.[151] This recurring prohibition was eventually codified and made permanent by the Department of Defense Authorization Act, 1985.[152]

In 1983, the Hyde Amendment process was extended to the Department of the Treasury and Postal Service Appropriations Act, prohibiting the use of funds for the Federal Employees Health Benefits Program (FEHBP) to pay for abortions, except when the life of the woman was in danger.[153] Prior to this restriction, federal government health insurance plans provided coverage for both therapeutic and nontherapeutic abortions.

The restriction on FEHBP funds followed an administrative attempt by the Office of Personnel Management (OPM) to eliminate nonlife-saving abortion coverage. OPM's actions were challenged by federal employee unions, and a federal district court later concluded that the agency acted outside the scope of its authority. In *American Federation of Government Employees v. AFL-CIO*, the court found that absent a specific congressional statutory directive, there was no basis for OPM's actions.[154]

The restriction on FEHBP funds was removed briefly in 1993, before being reinstated by the 104th Congress. That Congress passed language prohibiting the use of FEHBP funds for abortions, except in cases where the life of the mother would be endangered or in cases of rape or incest.[155]

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[147] Pub. L. No. 93-189, § 2, 87 Stat. 714, 716 (1973).

[148] *See, e.g.*, Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, div. H, tit. V, § 506 (2018).

[149] *See* note 125.

[150] Pub. L. No. 103-112, tit. V, § 509, 107 Stat. 1082, 1113 (1993).

[151] Pub. L. No. 95-457, tit. VIII, § 863, 92 Stat. 1231, 1254 (1978).

[152] Pub. L. No. 98-525, tit. XIV, § 1401(e)(5)(A), 98 Stat. 2492, 2618 (1984) (codified at 10 U.S.C. § 1093).

[153] *See* Pub. L. No. 98-151, § 101(f), 97 Stat. 964, 973 (1983) (referencing H.R. 4139, the Treasury, Postal Service and General Government Appropriations Act, 1984, as passed by the House of Representatives on October 27, 1983). Section 618 of H.R. 4139 stated: "No funds appropriated by this Act shall be available to pay for an abortion, except where the life of the mother would be endangered if the fetus were carried to term, or the administrative expenses in connection with any health plan under the Federal employees health benefit program which provides any benefits or coverages for abortions, except where the life of the mother would be endangered if the fetus were carried to term, under such negotiated plans after the last day of the contracts currently in force."

[154] 525 F.Supp.250 (D.D.C. 1981).

[155] Pub. L. No. 104-52, tit. V, §§ 524, 525, 109 Stat. 468, 495 (1995).

Under Department of Justice appropriations, funding of abortions in prisons is prohibited, except where the life of the mother is endangered, or in cases of rape or incest. First enacted as part of the FY1987 continuing appropriations measure,[156] this provision has been reenacted as part of the annual spending bill in each subsequent fiscal year.[157]

Finally, since 1979, restrictive abortion provisions have been included in appropriations measures for the District of Columbia (DC). The passage of the District of Columbia Appropriations Act, 1989, marked the first successful attempt to extend such restrictions to the use of DC funds, as well as federal funds.[158] Under the so-called "Dornan Amendment," DC was prohibited from using both appropriated funds and local funds to pay for abortions. In 2009, Congress lifted the restriction on the use of DC funds to pay for abortions. Under the Consolidated Appropriations Act, 2010, only federal funds were restricted.[159] The Dornan Amendment has since been reimposed.[160]

Other Legislation

In addition to the temporary funding limitations included in appropriations bills, abortion restrictions of a more permanent nature have been enacted in a variety of contexts since 1970. For example, the Family Planning Services and Population Research Act of 1970 bars the use of funds for programs in which abortion is a method of family planning.[161]

The Legal Services Corporation Act of 1974 prohibits lawyers in federally funded legal aid programs from providing legal assistance for procuring nontherapeutic abortions and prohibits legal aid in proceedings to compel an individual or an institution to perform an abortion, assist in an abortion, or provide facilities for an abortion.[162]

The Pregnancy Discrimination Act provides that employers are not required to pay health insurance benefits for abortion except to save the life of the mother, but does not preclude employers from providing abortion benefits if they choose to do so.[163]

The Civil Rights Restoration Act of 1988 states that nothing in the measure either prohibits or requires any person or entity from providing or paying for services related to abortion.[164]

The Civil Rights Commission Amendments Act of 1994 prohibits the commission from studying or collecting information about U.S. laws and policies concerning abortion.[165]

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[156] Pub. L. No. 99-591, tit. II, § 209, 100 Stat. 3341, 3341-56 (1986).

[157] *See, e.g.*, Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, div. B, tit. II, § 202 (2018).

[158] Pub. L. No. 100-462, tit I. § 117, 102 Stat. 2269, 2269-9 (1988).

[159] Pub. L. No. 11-117, div. C, tit. VIII, § 814, 123 Stat. 3034, 3224 (2009).

[160] Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, div. E, tit. VIII, § 810 (2018).

[161] 42 U.S.C. § 300a-6.

[162] 42 U.S.C. § 2996f(b)(8).

[163] 42 U.S.C. § 2000e(k).

[164] 20 U.S.C. § 1688.

[165] 42 U.S.C. § 1975a(f).

Health Reform

The Patient Protection and Affordable Care Act (ACA) was enacted on March 23, 2010, to reduce the number of uninsured individuals and restructure the private health insurance market.[166] The ACA includes provisions that address the coverage of abortion services by qualified health plans that are available through health benefit exchanges (exchanges). The ACA's abortion provisions have been controversial, particularly with regard to the use of premium tax credits or cost-sharing subsidies to obtain health coverage that includes coverage for elective or nontherapeutic abortion services.[167]

In addressing the coverage of abortion services by qualified health plans offered through an exchange, the ACA refers to the Hyde Amendment to distinguish between two types of abortions: abortions for which federal funds appropriated for HHS may be used, and abortions for which such funds may not be used (elective abortions).[168] Under the ACA, individuals who receive a premium tax credit or cost-sharing subsidy are permitted to select a qualified health plan that includes coverage for elective abortions. However, to ensure that funds attributable to such a credit or subsidy are not used to pay for elective abortion services, the ACA prescribes payment and accounting requirements for plan issuers and enrollees.[169]

Under the ACA, the issuer of a qualified health plan must determine whether to provide coverage for either elective abortions or abortions for which federal funds appropriated for HHS are permitted.[170] It appears that a plan issuer could also decide not to cover either type of abortion. The ACA also permits a state to prohibit abortion coverage in exchange plans by enacting a law with such a prohibition.[171]

The ACA indicates that an issuer of a qualified health plan that provides coverage for elective abortions cannot use any funds attributable to a premium tax credit or cost-sharing subsidy to pay for such services.[172] The issuer of a qualified health plan that provides coverage for elective abortions is required to collect two separate payments from each enrollee in the plan: one payment that reflects an amount equal to the portion of the premium for coverage of health services other than elective abortions; and another payment that reflects an amount equal to the actuarial value of the coverage for elective abortions.[173] The plan issuer is required to deposit the separate payments into separate allocation accounts that consist solely of each type of payment and that are used exclusively to pay for the specified services.[174] State health insurance commissioners ensure compliance with the segregation requirements in accordance with applicable provisions of generally accepted accounting requirements, Office of Management and

[166] Pub. L. No. 111-148, 124 Stat. 119 (2010).

[167] For additional information on abortion and the Patient Protection and Affordable Care Act, *see* CRS Report R41013, *Abortion and the Patient Protection and Affordable Care Act*, by Jon O. Shimabukuro.

[168] 42 U.S.C. § 18023(b)(1)(B).

[169] *Id*. § 18023(b)(2).

[170] *Id*. § 18023(b)(1)(A).

[171] *Id*. § 18023(a)(1).

[172] *Id*. § 18023(b)(2)(A).

[173] *Id*. § 18023(b)(2)(B)(i).

[174] *Id*. § 18023(b)(2)(B)(ii).

Budget circulars on funds management, and Government Accountability Office guidance on accounting.[175]

To determine the actuarial value of the coverage for elective abortions, the plan issuer estimates the basic per enrollee, per month cost, determined on an average actuarial basis, for including such coverage.[176] The estimate may take into account the impact on overall costs of including coverage for elective abortions, but cannot take into account any cost reduction estimated to result from such services, such as prenatal care, delivery, or postnatal care.[177] The per month cost has to be estimated as if coverage were included for the entire population covered, but cannot be less than $1 per enrollee, per month.[178]

Under the ACA, a qualified health plan that provides coverage for elective abortions is also required to provide notice of such coverage to enrollees as part of a summary of benefits and coverage explanation at the time of enrollment.[179] The notice, any plan advertising used by the issuer, any information provided by the exchange, and any other information specified by the Secretary provides information only with respect to the total amount of the combined payments for elective abortion services and other services covered by the plan.[180]

The ACA also provides for conscience protection and the preservation of certain state and federal abortion-related laws. The ACA prohibits exchange plans from discriminating against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions.[181] State laws concerning the prohibition or requirement of coverage or funding for abortions, and state laws involving abortion-related procedural requirements are not preempted.[182] Federal conscience protection and abortion-related antidiscrimination laws, as well as Title VII of the Civil Rights Act of 1964, are also not affected.[183]

Legislation in the 115th Congress

FY2018 Appropriations

On March 23, 2018, President Donald J. Trump signed H.R. 1625, the Consolidated Appropriations Act, 2018.[184] The measure provided FY2018 funds for foreign operations, the District of Columbia, HHS, and other federal agencies. Long-standing funding restrictions on abortion and abortion-related services, including restrictions on the use of federal and local DC funds to pay for abortions, were retained.

With regard to foreign operations, none of the appropriated funds could be made available to an organization or program that supported or participated in the management of a program of

[175] *Id*. § 18023(b)(2)(E)(i).

[176] *Id*. § 18023(b)(2)(D)(i).

[177] *Id*. § 18023(b)(2)(D)(ii)(I).

[178] *Id*. § 18023(b)(2)(D)(ii)(III).

[179] *Id*. § 18023(b)(3)(A).

[180] *Id*. § 18023(b)(3)(B).

[181] *Id*. § 18023(b)(4).

[182] *Id*. § 18023(c)(1).

[183] *Id*. § 18023(c)(2).

[184] Pub. L. No. 115-141, 132 Stat. 348 (2018).

coercive abortion or involuntary sterilization.[185] In addition, appropriated funds were not available for the performance of abortions as a method of family planning, or to motivate or coerce any person to practice abortions.[186] Appropriated funds were also not available to lobby for or against abortion.[187] To reduce reliance on abortions in developing nations, funds were available only for voluntary family planning projects that offered a broad range of family planning methods and services. Such voluntary family planning projects were required to meet specified requirements.

Contributions to the United Nations Population Fund (UNFPA) were conditioned on the entity not funding abortions.[188] In addition, amounts appropriated to the UNFPA were required to be kept in an account that was separate from the UNFPA's other accounts.[189] The UNFPA could not commingle funds provided under H.R. 1625 with the entity's other funds.

The omnibus measure prohibited the use of appropriated funds to pay for an abortion or for any administrative expenses related to a health plan in the FEHBP that provided benefits or coverage for abortions.[190] This prohibition, however, did not apply when the life of the mother would be endangered if the fetus were carried to term, or in the case of rape or incest.[191] Funds provided to the Department of Justice could also not be used to pay for an abortion, except when the life of the mother would be endangered if the fetus were carried to term, or in the case of rape or incest.[192]

Finally, funds appropriated for HHS, as well as funds derived from any trust fund that received appropriations, could not be used to pay for abortions except in cases of rape or incest, or when a woman who suffered from a physical disorder, injury, or illness would have her life jeopardized if an abortion was not performed.[193]

Additional Legislation

On January 24, 2017, the House passed H.R. 7, the No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act of 2017, by a vote of 238-183. Introduced by Representative Christopher H. Smith, the bill would have amended Title 1 of the U.S. Code to add new sections that would have permanently prohibited the use of federal funds for abortion.[194] Unlike the Hyde Amendment and the other Hyde-type restrictions that have been included annually in various appropriations measures, the proposed sections would not have to be renewed each year. Moreover, these funding limitations would have applied to all federal funds and not just those specifically appropriated for HHS and other federal agencies.

H.R. 7 would have imposed additional restrictions on the availability of abortion. The measure would have amended the Internal Revenue Code to indicate that a health plan that included

[185] Pub. L. No. 115-141, div. K, tit. III, 132 Stat. 348, 844 (2018).

[186] *Id*.

[187] *Id*.

[188] Pub. L. No. 115-141, div. K, tit. VII, § 7082(d)(2), 132 Stat. 348, 965 (2018).

[189] *Id*. § 7082(d)(1).

[190] Pub. L. No. 115-141, div. E, tit. VI, § 613, 132 Stat. 348, 584 (2018).

[191] *Id*. § 614.

[192] Pub. L. No. 115-141, div. B, tit. II, § 202, 132 Stat. 348, 425 (2018).

[193] Pub. L. No. 115-141, div. H, tit. V, §§ 506, 507, 132 Stat. 348, 763-64 (2018).

[194] H.R. 7, 115th Cong. § 101 (2017).

coverage for elective abortions was not a "qualified health plan" for purposes of the availability of a premium tax credit.[195] Under the ACA, recipients of a premium tax credit are permitted to select a qualified health plan that includes elective abortion coverage, so long as the plan enrollee and plan issuer comply with specified payment and accounting requirements.[196] Thus, if enacted, H.R. 7 would have likely affected a recipient's decision to select a health plan that covered elective abortions.

Finally, H.R. 7 would have made permanent the Dornan Amendment, which restricts the use of local DC funds to pay for abortions,[197] and would have amended the ACA to require plans to disclose abortion services coverage in marketing or advertising materials, comparison tools, and benefit summaries.[198] H.R. 7 was received in the Senate on January 30, 2017, but no further action was taken. The Senate also took no action on a companion bill, S. 184.

On October 3, 2017, the House passed H.R. 36, the Pain-Capable Unborn Child Protection Act, by a vote of 237-189. Introduced by Representative Trent Franks, the bill would have prohibited the performance or attempted performance of an abortion if the probable postfertilization age of the "unborn child" was 20 weeks or greater.[199] The prohibition would not have applied to abortions that are necessary to save the life of a pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury. The bill's prohibition would also not have applied when a pregnancy is the result of rape and certain specified conditions are satisfied. Individuals who violated H.R. 36 would have been subject to a fine under Title 18, U.S. Code, imprisonment for not more than five years, or both.[200] H.R. 36 was received in the Senate on October 4, 2017, but no further action was taken on the measure. A cloture vote on S. 2311, a companion bill, was taken in the Senate on January 29, 2018. Cloture on the motion to proceed to consideration of S. 2311 was rejected by a vote of 51-46.

On January 19, 2018, the House passed H.R. 4712, the Born-Alive Abortion Survivors Protection Act, by a vote of 241-183. Introduced by Representative Marsha Blackburn, the bill would have required care to be provided to a fetus "born alive" following an abortion or attempted abortion. Under the measure, any health care practitioner who was present at the time the fetus was "born alive" would have been required to exercise the same degree of skill, care, and diligence necessary to preserve the life and health of the fetus as a "reasonably diligent and conscientious health care practitioner would render to any other child born alive at the same gestational age."[201] A health care practitioner who failed to exercise the specified level of care would have been subject to a fine, imprisonment for not more than five years, or both.[202] H.R. 4712 was received in the Senate on January 20, 2018, but no further action was taken on the measure. The Senate also declined to consider a companion bill, S. 220.

On May 4, 2017, the House passed H.R. 1628, the American Health Care Act of 2017, by a vote of 217-213. Introduced by Representative Diane Black, the reconciliation bill would have made two notable changes related to the ACA. First, it would have amended Section 36B(c)(3)(A) of

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[195] *Id*. § 201(a)(1)(A).

[196] For additional information on abortion and the Patient Protection and Affordable Care Act, *see* CRS Report R41013, *Abortion and the Patient Protection and Affordable Care Act*, by Jon O. Shimabukuro.

[197] H.R. 7, 115th Cong. § 101 (2017).

[198] *Id*. § 202.

[199] H.R. 36, 115th Cong. § 3 (2017).

[200] *Id*.

[201] H.R. 4712, 115th Cong. § 3(a) (2017).

[202] *Id*.

the Internal Revenue Code to provide that a health plan that included coverage for elective abortions would not be considered a "qualified health plan."[203] Because the tax credit provided under Section 36B is available only to enrollees in a qualified health plan, the change could have affected an individual's choice of health coverage. Second, the bill would have defined the term "qualified health plan" to exclude any plan that included coverage of elective abortions for purposes of Section 45R of the Internal Revenue Code, which provides a small employer health insurance credit based on employee enrollment in a qualified health plan.[204] The bill would have also restricted the availability of federal funds for certain nonprofit organizations that provide elective abortions.[205]

H.R. 1628 was considered by the Senate in July 2017 and remained on its calendar until the end of the session. Notably, two discussion drafts prepared by the Senate Committee on the Budget—the Better Care Reconciliation Act (BCRA)[206] and the Obamacare Repeal Reconciliation Act (ORRA)[207]—included similar provisions with regard to abortion. The drafts were written as amendments in the nature of a substitute, intended to replace the House-passed provisions of H.R. 1628, if adopted. However, neither the BCRA nor the ORRA was adopted.

Legislation in the 116th Congress

FY2019 Appropriations

On February 15, 2019, President Trump signed H.J. Res. 31, the Consolidated Appropriations Act, 2019.[208] The measure retained the same long-standing funding restrictions on abortion and abortion-related services for the Department of Justice, FEHBP, the District of Columbia, and foreign operations. Abortion funding restrictions applicable to HHS's appropriations were included in H.R. 6157, the Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019.[209] These restrictions were similar to those included in the Consolidated Appropriations Act, 2018, for HHS. President Trump signed H.R. 6157 on September 28, 2018.

Additional Legislation

Two abortion-related bills that were passed by the House during the 115th Congress, but not considered in the Senate, received some attention by Senators in the 116th Congress. Cloture votes were taken on S. 109, the No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act of 2019, and S. 311, the Born-Alive Abortion Survivors Protection Act. These measures were generally similar to the versions passed by the House in the 115th Congress. On January 17, 2019, the Senate voted against further consideration of S. 109 by a vote of 48-47. Cloture on the motion to proceed to consideration of S. 311 was rejected by a vote of 53-44 on February 25, 2019. Companion bills have been introduced in the House, but have yet to be considered.

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[203] H.R. 1628, 115th Cong. § 202(a)(1)(B) (2017).

[204] *Id*. § 203(b)(2).

[205] *Id*. § 103(b)(1).

[206] S. Amdt. 270, 115th Cong., 163 Cong. Rec. S4200 (daily ed. July 25, 2017).

[207] S. Amdt. 271, 115th Cong., 163 Cong. Rec. S4218 (daily ed. July 25, 2017).

[208] Pub. L. No. 116-6 (2019).

[209] Pub. L. No. 115-245 (2018).

Author Information

Jon O. Shimabukuro
Legislative Attorney

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