SUPREME COURT OF THE STATE OF NEW YORK
APPELLATE DIVISION, FIRST DEPARTMENT

JANE HOPE, et al.,	
Plaintiffs-Respondents,	
v.	N.Y. County Index No. 21073/90
CESAR PERALES, et al.,	
Defendants-Appellants.	

BRIEF OF *AMICI CURIAE*
THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS; THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, DISTRICT II, NEW YORK STATE; THE AMERICAN FOUNDATION FOR AIDS RESEARCH; THE AMERICAN MEDICAL WOMEN'S ASSOCIATION; AMERICAN PUBLIC HEALTH ASSOCIATION; BENEDICT HEALTH CENTER; CHOICES WOMEN'S MEDICAL CENTER; THE COMMUNITY HEALTH CARE ASSOCIATION OF NEW YORK STATE; THE CORTLAND COUNTY HEALTH DEPARTMENT; FAMILY PLANNING ADVOCATES OF NEW YORK STATE, INC.; INTERNATIONAL FUND FOR HEALTH AND FAMILY PLANNING, LTD.; THE JAMAICA HOSPITAL; THE LONG ISLAND COLLEGE HOSPITAL; THE NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC.; THE NEW YORK GRAY PANTHERS; PATHFINDER INTERNATIONAL; PLANNED PARENTHOOD OF FINGER LAKES; PLANNED PARENTHOOD HEALTH SERVICES OF NORTHEASTERN NEW YORK, INC.; PLANNED PARENTHOOD OF NASSAU COUNTY, INC.; ST. LUKE'S-ROOSEVELT HOSPITAL CENTER; SEGUNDO RUIZ BELVIS NEIGHBORHOOD FAMILY CARE CENTER; WOMANCARE CLINIC; WOMEN'S HEALTH EDUCATION PROJECT; THE WOMEN'S MEDICAL ASSOCIATION OF NEW YORK CITY; AND YWCA OF BROOKLYN IN SUPPORT OF PLAINTIFFS-RESPONDENTS

DEBEVOISE & PLIMPTON
875 Third Avenue
New York, New York 10022
(212) 909-6000

Attorneys for *Amici Curiae*

New York, New York
February 3, 1992

TABLE OF CONTENTS

BRIEF OF AMICI CURIAE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, et al., IN SUPPORT OF PLAINTIFFS-RESPONDENTS

TABLE OF AUTHORITIES

CASES

STATUTES

CONSTITUTIONS

MISCELLANEOUS

SUPREME COURT OF THE STATE OF NEW YORK
APPELLATE DIVISION, FIRST DEPARTMENT

JANE HOPE, et al.,

Plaintiffs-Respondents,

v.

CESAR PERALES, et al.,

Defendants-Appellants.

BRIEF OF AMICI CURIAE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, et al., IN SUPPORT OF PLAINTIFFS-RESPONDENTS

The American College of Obstetricians and Gynecologists and twenty-four other organizations dedicated to the protection of women's health submit this Brief as *amici curiae* to urge this Court to affirm the decision of the Supreme Court, New York County, entered on June 12, 1991.

I.

INTERESTS OF AMICI CURIAE AND PRELIMINARY STATEMENT

Amici represent thousands of health care providers from diverse backgrounds. They believe that the Supreme Court properly recognized that the medical benefits provided by New York's Prenatal Care Assistance Program must be made available to all needy women,

without regard to how they exercise the fundamental right to procreative choice. Descriptions of individual *amici* are set forth in the Appendix to this Brief.

The Prenatal Care Assistance Program, Chapter 584 of the Laws of 1989 ("Chapter 584"), provides funds to women with incomes between 100 and 185% of the federal poverty line for all medical and other services related to pregnancy and childbirth except abortions, even those that are medically necessary. The order and judgment of the Supreme Court correctly held that this funding scheme violates the due process clause (art. I, § 6), the equal protection clause (art. I, § 11), and other provisions of the New York State Constitution.

The Plaintiffs-Respondents' brief provides this Court with background to the enactment of Chapter 584, a description of its provisions, and a summary of the decision of the Supreme Court. *Amici* will not reiterate that information here. The Plaintiffs-Respondents' brief also sets forth the full array of reasons why Chapter 584 violates the New York State Constitution, and *amici* endorse that brief in full. In this Brief, *amici* explain why Chapter 584's attempt to discriminate in the distribution of medical benefits on the basis of a woman's exercise of her right to procreative choice violates the equal protection guarantee of the New York Constitution and its requirement that assistance to the needy be distributed on a nondiscriminatory basis.

II.

MEDICAL IMPLICATIONS OF PREGNANCY AND ABORTION

Like any evaluation of abortion rights, review of the Supreme Court's decision in this case should be undertaken only with a full appreciation of the medical facts surrounding pregnancy and abortion. As medical care providers, *amici* have both a unique expertise in this area and a particular interest in ensuring the health of those women affected by Chapter 584. Accordingly, *amici* offer in this section an extended discussion of the medical background of pregnancy and abortion in order to provide a medical context for the Court's consideration of the fundamental right at issue.

A. General Background of Abortion

Abortion is the termination of a pregnancy in any way before the fetus is viable. *Williams Obstetrics* 467 (Jack A. Pritchard et al., eds., 17th ed. 1985); David N. Danforth et al., *Obstetrics and Gynecology* 231 (5th ed. 1986). Viability is defined as the point at which the fetus has a reasonable potential for survival outside the woman's uterus. *Williams Obstetrics*, at 467. An abortion may be spontaneous (unintentional) or induced (intentional). Approximately 30% of all U.S. pregnancies are terminated by induced abortion. Alan Guttmacher Institute, *Abortion and Women's Health: A Turning Point for America?* 22 (1990).

Abortions are performed in hospitals, abortion or general surgical clinics, and private physicians' offices. The vast majority take place in metropolitan areas; in 1985, for

example, only two percent of all U.S. abortions took place in rural areas. Stanley K. Henshaw et al., *Abortion Services in the United States, 1984 and 1985*, 19 Fam. Plan. Persp. 63, 64, 67 (1987).

Virtually all abortions performed in the first trimester of pregnancy are by vacuum aspiration, by which a doctor dilates the woman's cervix, inserts a tube into her uterus, and removes the contents by suction. The procedure requires about five minutes and usually only local anesthesia. *Abortion and Women's Health*, at 23.

The most common method of second-trimester abortion is dilation and evacuation, by which the physician dilates the woman's cervix by either inserting a succession of rods of graduated size or an osmotic dilator that absorbs fluid and causes the cervix to open. This process can take several hours, sometimes overnight. Once the cervix is dilated, the doctor suctions the uterus, and sometimes also uses forceps to insure the removal of all tissue. The procedure usually takes no more than 10 minutes. *Abortion and Women's Health*, at 23-24.

Abortions performed late in the second trimester usually require medical induction, by which the doctor either injects a saline solution into the uterus, thus inducing contractions and causing the expulsion of the fetus, or administers prostaglandin vaginal suppositories or intramuscular injections, which also induce contractions and cause expulsion. The contractions provoked by these methods are painful, and the procedure can last several hours. *Abortion and Women's Health*, at 24.

Eighty-nine percent of abortions are performed during the first twelve weeks of gestation; about half of all abortions are performed before eight weeks' gestation. Ten per-

cent are performed after twelve weeks, with less than one percent taking place after twenty weeks. Stanley K. Henshaw et al., *Characteristics of U.S. Women Having Abortions, 1987*, 23 Fam. Plan. Persp. 75, 79 (1991). Only 0.01% of all abortions occur in the third trimester of pregnancy. *Abortion and Women's Health*, at 23. The women who have abortions are 65% white, 59% under twenty-five years old, and 82% unmarried. A majority, 53%, have had no previous live births, and 58% have had no previous abortions. *Characteristics of U.S. Women Having Abortion*, at 75. By 1989, about sixteen million American women had had legal abortions. At current rates, nearly half of all women of reproductive age will have had an abortion by age forty-five. *Abortion and Women's Health*, at 22.

B. Health Effects of Pregnancy and Abortion

In 1973, the United States Supreme Court observed that until the second trimester of pregnancy, maternal mortality from abortion was lower than maternal mortality from childbirth. *Roe v. Wade*, 410 U.S. 113, 149, 163 (1973). Since the landmark decision in *Roe v. Wade*, there has been a dramatic decrease in the number of illegal abortions and abortion-related deaths. In 1973, the risk of dying from an abortion was 3.4 deaths per 100,000 legal abortions; in 1977, the rate was 1.3.[1] By 1985, the risk of dying from a legal

---

[1] The risk of mortality from unlawful abortions was estimated in 1975 to be eight times greater than the risk from legal abortions. *See* Hillary Kunins & Allan Rosenfield, *Abortion: A Legal and Public Health Perspective*, 12 Ann. Rev. of Pub. Health 361, 372 (1991). Between 1940 and 1972, more than 75% of abortion deaths were the

(continued...)

abortion had decreased to only 0.4 deaths per 100,000 legal abortions. *Abortion and Women's Health*, at 28. In fact, abortion is one of the most common and one of the safest of all medical procedures. It poses half the risk of death as does a tonsillectomy and one one-hundredth the risk of death involved with an appendectomy. Warren M. Hern, *Abortion Practice* 23-24 (1984). Abortion is safer than almost any other surgical procedure, safer even than a shot of penicillin. Kelli Conlin, *One, Two, Many Dr. Hayats?*, Newsday, Dec. 4, 1991, at 88

More significantly, abortion poses less risk to a pregnant woman's life than does a pregnancy carried to full term. A woman is twenty-five times more likely to die from carrying a pregnancy to term than from abortion. American College of Obstetricians and Gynecologists, *Public Health Policy Implications of Abortions* 9 (1990).

In addition, morbidity (meaning illness) is much more frequent from pregnancy than from legal abortion. Of every ten women who experience pregnancy and childbirth, six are treated for some medical complications, and three are treated for major complications. Rachel Benson Gold et al., *Blessed Events and the Bottom Line: Financing Maternity Care in the United States* 10 (1987). As many as 90% of pregnant women develop gastrointestinal

---

[1](...continued)
consequence of unlawful abortions. Between 1972 and 1974, the total number of abortion deaths declined from 88 to 48, and the deaths from unlawful abortions declined from 39 to 5. *See* William Cates, Jr. & Roger W. Rochat, *Illegal Abortions in the United States: 1972-74*, 8 Fam. Plan. Persp. 86, 87, 92 (1976). This indicates that 85% of the decrease in abortion deaths between 1972 and 1974 was from reduced mortality from unlawful abortions.

symptoms, including nausea and vomiting. *Obstetrics and Gynecology*, at 334. Nausea and vomiting can sometimes be so serious as to require medication, hospitalization, and ultimately the termination of the pregnancy. Brian Little, *Pernicious Hyperemesis Gravidarum*, 247 J. Am. Med. Ass'n 521 (1982). Other common problems include fatigue, varicose veins, hemorrhoids, headache, and backache. *Williams Obstetrics*, at 261-63.

The most common health problems associated with pregnancy occur during labor and delivery. These problems include such complications as severe lacerations of the perineal muscle, cervix, or vagina and severe postpartum hemorrhage. Due to complications, roughly two out of ten deliveries are by cesarean section, a major surgical procedure that invariably subjects women to substantial risks to life and health. *Blessed Events and the Bottom Line*, at 10. The medical risks of cesarean section include death, operative injuries to the urinary tract and bowel, wound abscess, wound dehiscence, evisceration, operative and postoperative hemorrhage, and paralytic ileus, in addition to surgical complications such as pulmonary emboli, venous thrombosis, and anesthesia-related morbidity. National Institute of Child Health, *Cesarean Childbirth: Report of a Consensus Development Conference* 156, 250 (1981). As many as one-third of cesarean patients suffer from postoperative infections. Helen I. Marieskind, *Cesarean Sections*, 7 Women & Health 179, 186 (1982).

By contrast, fewer than one-half of one percent of all abortion patients experience a major complication requiring hospitalization. *Abortion and Women's Health*, at 30. Of 150,000 abortions reported in New York State in 1989, fewer than 2800, or less than 2%,

involved any medical complications. Robert D. McFadden, *Abortion Mills Thriving Behind Secrecy and Fear*, N.Y. Times, Nov. 24, 1991, § 1, at 1, col. 2.

C. Health Risks of Pregnancy To Women With Complicating Conditions

In addition to the general health risks of pregnancy, there are numerous instances when a woman's pre-existing health problems make pregnancy particularly dangerous or life-threatening. For those women with complicating conditions such as sickle-cell anemia, heart disease, hypertension, eclampsia, diabetes, renal disease, severe asthma, liver disease, epilepsy, malignant breast tumors, phlebitis and certain respiratory, urinary, and neuro-muscular disorders, continuation of pregnancy carries grave risks for the health of both the mother and the fetus. *See generally* Joseph J. Rovinsky, *Diseases Complicating Pregnancy in Gynecology and Obstetrics: The Health Care of Women* 697-99 (Seymour Romney et al., eds., 2d ed. 1981). The availability of abortion to pregnant women in these high-risk groups is critical to their health. Christopher Tietze, *The Public Health Effects of Legal Abortion in the United States*, 16 Fam. Plan. Persp. 26, 26-27 (1984).

Hypertension. Hypertensive diseases are the leading cause of maternal death in the world today and the second leading cause in the United States. *Clinical Obstetrics* 647 (Carl Pauerstein, ed., 1987). These diseases complicate some eight to ten percent of all

pregnancies, *id.* at 645, and are associated with up to thirty percent of maternal deaths. Affidavit Dr. Rosenfield ¶ 12, A. 169.[2]

Hypertension may be induced or aggravated by pregnancy. *Williams Obstetrics*, at 526-29. Although hypertension can be controlled in many cases, pregnant women with the condition are at increased risk for cerebrovascular accidents (strokes), abruptio placentae (premature separation of the placenta from the uterus), and disseminated intravascular coagulopathy (a severe bleeding disorder). *Id.* at 528.

Diabetes. For the more than one and a half million women of childbearing age who have diagnosed diabetes, risks of pregnancy complications abound. *Maternal-Fetal Medicine: Principles and Practice* 925 (Robert K. Creasey & Robert Resnik, eds., 2d ed. 1989). Pregnant women with diabetes are four times more likely than women without diabetes to develop dangerously severe hypertension, as well as more likely to develop infections of greater severity, to injure their birth canals during vaginal delivery, to require a caesarian section, and to hemorrhage after delivery. *Williams Obstetrics*, at 600. For diabetic women with nephropathy or proliferative retinopathy, pregnancy may cause rapid progression of vascular changes resulting in visual loss. *Medical Complications During Pregnancy*, 56-58 (Gerard N. Burrow & Thomas F. Ferris, eds., 3d ed. 1988).

---

[2] The affidavits submitted to the trial court in support of the order to show cause will hereinafter be referred to by the last name of the affiant, with the affidavit citation followed by its location in the Joint Appendix, designated "A._____."

Cardiovascular Diseases. Nearly 2% of pregnant women have some form of heart disease, exposing them to significant risks to their health or endangering their lives. *Clinical Obstetrics*, at 627-28. For women with myocardiopathy, pulmonary hypertension, Marfan's syndrome, and Eisenmenger's syndrome, therapeutic abortion is dramatically safer than continuing pregnancy. *Maternal-Fetal Medicine*, at 747-48, 752. The approximate maternal mortality rate for women with aortic valve disease is 10-20%, for women with Marfan's syndrome, 25-50%, for women with Eisenmenger's syndrome as high as 70%, and for women with primary pulmonary hypertension, 50%. *Id.* at 748. Pregnancy is absolutely contraindicated for women with Eisenmenger's syndrome and is not advisable for any woman with pulmonary hypertension, whatever the cause. Rosenfield ¶ 11(d-e), A. 169.

Sickle-Cell Anemia. Six to thirteen percent of the American black population carries the sickle-cell anemia trait. *Medical Complications*, at 73. Women with the sickle-cell trait have an increased risk of nephritis, bacteriuria and hematuria during pregnancy. *Id.* For the 0.2% of carriers who develop sickle-cell disease, pregnancy poses extremely serious risks. *Id.* The maternal mortality rate for women with sickle-cell anemia is about 2%. *Id.* In addition, pregnancy can precipitate more frequent and severe sickle-cell crises and more infections and pulmonary dysfunction. *Williams Obstetrics*, at 569. An increased risk of congestive heart failure, pre-eclampsia, and eclampsia have also been noted. *Medical Complications*, at 73-74.

Renal Diseases. Women with renal diseases risk exacerbating the underlying disease by becoming pregnant. *Medical Complications*, at 289. Women with systemic lupus erythe-

matosus may experience a worsening of the disease and deterioration in renal function during or following pregnancy. Rosenfield ¶ 14, A. 170.

Other Conditions. Severe asthma can be exacerbated by pregnancy, and studies have shown an increased incidence of perinatal mortality. *Medical Complications*, at 456. Women who suffer from frequent epileptic seizures usually experience more fits during pregnancy, and the offspring of epileptic women have a higher incidence of epilepsy, mental retardation and microcephaly. *Id.* at 495-96.

Pregnancy may also accelerate the spread of malignant breast tumors that are estrogen-receptor positive. Because of changes in blood coagulation during pregnancy, phlebitis can become life-threatening; however, preventive drug treatments are dangerous to the fetus. Finally, severe liver disease leading to portal hypertension and/or esophagal varices exposes pregnant women to a high risk of hemorrhage. Rosenfield ¶ 16, A. 171.

D. Health Risks of Restricted Access to Abortion

Chapter 584 denies abortion funding to low-income women, thus limiting — if not eliminating — their ability to obtain abortion services. Women whose income is 100-185% of the federal poverty line cannot easily or quickly raise the funds necessary to pay for an abortion. *See generally* Romeo ¶¶ 7-11, A. 281-85; Rose ¶¶ 6-9, A. 288-90. They will thus be compelled toward one of two alternatives. First, they may be constrained to carry a fetus to term involuntarily. Second, they may scrape for funds to pay for the abortion themselves, often sacrificing essentials for themselves and their families to do so, and even-

tually have an abortion at greater risk to their health than if the abortion were obtained promptly. From a medical and health perspective, neither of these options is acceptable.

1. Compelled Pregnancy.

Experience shows that decreased state funding for abortions increases the proportion of pregnancies resulting in live births. Carol C. Korenbrot et al., *Trends in Rates of Live Births and Abortions Following State Restrictions on Public Funding of Abortion*, Pub. Health Rep. 555-62 (Nov./Dec. 1990); Dennis B. Smith & G. Franklin Carl, *Effect of the Hyde Amendment*, 247 J. Am. Med. Ass'n 1128 (1982). In states where Medicaid does not pay for abortions, 18-23% of Medicaid eligible women who want an abortion nevertheless carry to term. James Trussell et al., *The Impact of Restricting Medicaid Financing for Abortion*, 12 Fam. Plan. Persp. 120-30 (1980). Lack of funding thus coerces some pregnant women who would have obtained an abortion had it been feasible for them to do so to instead carry the fetus to term. Romeo ¶ 11(b), A. 284-85; Rose ¶ 6, A. 287-88. This compromises their physical and mental health. Moe ¶¶ 6-9, A. 103-05.

In addition, the health risks of pregnancy are exacerbated when a woman carries an unwanted pregnancy to term. Women with negative attitudes toward their pregnancies have been found to suffer a higher rate of postpartum infection, hemorrhages, and postpartum depression than those with a desire to carry their pregnancies to term. Willard Cates, Jr., *Legal Abortion: The Public Health Record*, 215 Sci. 1586, 1587 (1982). Unwanted pregnancies can aggravate pre-existing mental illness and cause severe mental disturbance in

patients with no prior history of psychopathology. Warren M. Hern, *Abortion Practice* 8 (1984); *Comprehensive Textbook of Psychiatry* (Harold I. Kaplan & Benjamin J. Sadock, eds., 4th ed. 1985); Belsky ¶¶ 3-13, A. 108-15. One study revealed that only 27% of women denied the right to choose abortion were able to cope fully with the resulting pregnancy and child. Half of the women showed signs of mental disturbance and strain for a considerable length of time after giving birth. Henry P. David, *Born Unwanted: Developmental Effects of Denied Abortion* 48 (1988).

By contrast, the experience of abortion causes few psychological problems. Adler et al., *Psychological Responses After Abortion*, 248 Sci. 41, 43 (1990). Most women respond to abortion with relief, and the incidence of severe negative responses is low. *Id.* at 41.

2. Delayed Abortions

The risks associated with abortion are minimal during the earliest stages. Thus, the earlier that women obtain the procedure, the better. The death rate from an abortion performed at or before eight weeks of pregnancy is 0.2 deaths per 100,000 procedures. *Abortion and Women's Health*, at 29. After the eighth week, abortion risks rise with each passing week of gestation. The risk of major complications increases by fifteen to thirty percent with each week of delay, and the risk of death increases by approximately 50% with every two weeks of delay. Willard Cates, Jr. & David A. Grimes, *Morbidity and Mortality of Abortion in the United States, in Abortion and Sterilization: Medical and Social Aspects* 155, 158, 171 (Jane Elizabeth Hodgson, ed., 1981).

By the time a woman is eleven to twelve weeks pregnant, the mortality rate increases to 0.6 per 100,000 abortions. *Abortion and Women's Health*, at 29. Women who are sixteen or more weeks pregnant are twenty-four times as likely to have fatal complications than women who abort at eight or fewer weeks. David A. Grimes, *Second-Trimester Abortions in the United States*, 16 Fam. Plan. Persp. 260, 263 (1984). Moreover, because only 17% of all abortion providers perform abortions after the sixteenth week of pregnancy, *Abortion Services in the United States, 1984 and 1985*, at 69, women who are beyond the sixteenth week of pregnancy face increased difficulty in gaining access to the procedure. At this point, delay in obtaining the procedure may become deprivation.

The ability to pay for an abortion is often the determining factor in whether a woman will be able to have an early, safe procedure.[3] The cost of an abortion in New York ranges from approximately $200 to approximately $3500 depending on the type of facility and the duration of a pregnancy. Hope ¶¶ 3-5, A. 97-99; Moe ¶ 4, A. 102-03; Henshaw ¶ 9, A. 139; Scarbrough ¶ 10, A. 196-97. Accordingly, low-income women suffer most from the

---

[3] The lower court in this case recognized that those in the 100-185% income category encounter hardships in attempting to save for an abortion. "Often such women are either forced to postpone the procedure increasing not only the medical risk to themselves but also the cost of the abortion, or to forego the procedure altogether, jeopardizing their own health." *Hope v. Perales*, 571 N.Y.S.2d 972, 979 (Sup. Ct. N.Y. Co. 1991). The record before the Court fully supported that conclusion. Plaintiff Hope, who discovered she was pregnant at twenty-one weeks of gestation spends almost all of her income on rent, food, and essentials. She could not raise the money necessary to pay for an abortion. Hope ¶¶ 3-5, A. 97-99. *See also* Alexander ¶ 7, A. 224-25; Scarbrough ¶¶ 6-10, A. 195-97; Dumois ¶ 7, A. 210. The longer it takes to raise funds, the more dangerous and expensive the procedure. Hope ¶ 5, A. 98-99; Crawley ¶¶ 3, 9, A. 263, 266.

deleterious — and sometimes fatal — effects of delayed abortions. One survey showed that of women who had abortions at sixteen or more weeks of gestation, almost half attributed the delay to trouble in arranging the abortion, with the most common problem cited being the time needed to raise funds to pay for the procedure. Another study, conducted in a state that does not provide Medicaid abortions, found that 22% of poor women who had second-trimester abortions would have had first-trimester abortions if they had been able to come up with the funds earlier. Many of these women paid for their abortions with money needed for daily living expenses. Stanley K. Henshaw & Lynn S. Wallisch, *The Medicaid Cutoff and Abortion Services for the Poor*, 16 Fam. Plan. Persp. 170, 178 (1984).[4]

E. The Effect of the Legalization of Abortion on the Safety of the Procedure

The decrease in abortion-related mortality and morbidity is attributable, in large measure, to the legalization of abortion since *Roe v. Wade*. Legalization has caused a notable shift toward earlier abortions. Every week of delay in obtaining an abortion increases health risks to the pregnant woman. In 1974, the year after legalization nationally,

---

[4] A lack of funds also makes it more difficult to consider the consequences of a fetal anomaly, such as Tay-Sachs disease, certain fetal trisomies, encephaly, hydrocephaly, open spina bifida, thanatophoric dwarfism, and cystic hygroma. Kaiser ¶¶ 6-8, 10-11, A. 150-51, 152-53; Rosenfield ¶¶ 19-22, A. 173-76; Elahi ¶ 3, A. 247-48; Moe ¶¶ 7-10, 12, A. 103-04, 106. Amniocentesis, the most reliable prenatal diagnostic test, is ideally performed after the fifteenth week of pregnancy, and often as late as the sixteenth and eighteenth week of pregnancy. By the time results are available, a woman who chooses to abort may have as little as three weeks before the twenty-four week time limit imposed by New York law to raise the thousands of dollars necessary for a late abortion. Kaiser ¶ 5, A. 149-50.

43% of abortions were performed in the eighth week of gestation; 10% were performed at more than fifteen weeks' gestation. By 1985, more than 50% of abortions took place before the eighth week of gestation and only 5% took place after the sixteenth week of gestation. Because earlier abortions are safer, the shift has helped to decrease complications. *Abortion: A Legal and Public Health Perspective*, at 373.

The legalization of abortion also has made the procedure safer by enabling physicians to gain training and experience in abortion methods, and by ending, for the most part, women's resort to self-induced abortions or incompetent abortionists. One study found that hospital admissions due to septic and incomplete abortions, two common adverse consequences of illegal abortions, declined markedly after legalization. *Id.*, at 372-73. By contrast, in countries where abortion remains illegal today, a high incidence of major complications is still common. A. Richards et al., *The Incidence of Major Abdominal Surgery After Septic Abortion — An Indicator of Complications Due to Illegal Abortion*, 68 S. African Med. J. 799 (1985).

Prior to the decision in *Roe v. Wade* and the consequent increased availability of legal, safe abortions, many desperate women pursued dangerous alternatives such as substandard practitioners or self-induced abortions. *See supra* note 1. In 1970, by liberalizing its abortion laws prior to *Roe v. Wade*, New York was one of the first states to acknowledge that denying or delaying access to abortions had exposed women — and particularly low-income women — to health risks. Although abortion today is a common, safe procedure, low-income women who cannot afford safe, legal abortions are still at risk of

obtaining illegal, substandard care or attempting self-induced abortions. Belsky ¶ 8, A. 111-12; Romeo ¶ 8, A. 282. *See also* Nancy Binkin et al., *Illegal Abortion Deaths in the United States: Why Are They Still Occurring?*, 14 Fam. Plan. Persp. 163, 165 (1982).

III.

SUMMARY OF ARGUMENT

The New York Constitution is an independent source of individual rights, and this Court has the obligation and authority to determine the reach of those rights. Among them is a woman's right to procreative choice, arising from both the right to personal autonomy in the sphere of childbearing and the right to personal control over medical treatment.

By discriminating against women who are otherwise eligible for medical benefits solely on the basis of their exercise of their right of procreative choice, Chapter 584 violates the New York guarantee of equal protection of the laws. Although Chapter 584 laudably promotes the health of needy women and the children they bear, its discriminatory denial of benefits to poor women seeking a medically necessary abortion places the lives and health of that class of pregnant women at great risk. This denial of funding does not in any way promote neonatal or maternal health or any other permissible goal. For the same reasons, the statute violates the New York constitutional requirement that assistance to the needy not be dispensed on the basis of criteria unrelated to need. Accordingly, this Court should affirm the Supreme Court's order extending the benefits of the program to otherwise eligible women seeking medically necessary abortions.

IV.

ARGUMENT

A. The Equal Protection Clause Of The New York State Constitution Is An Independent Source of Individual Rights.

When "the Federal Constitution as interpreted by the [United States] Supreme Court [has fallen] short of adequate protection of [New York] citizens," New York courts "have not hesitated . . . to rely upon the principle that that document defines the minimum level of individual rights and leaves [a] State[] free to provide greater rights for its citizens through its Constitution." *Cooper v. Morin*, 49 N.Y.2d 69, 79 (1979). *See, e.g., Rivers v. Katz*, 67 N.Y.2d 485, 493 (1986) (right to bodily autonomy and medical decisionmaking). Indeed, in New York, "there is a long tradition of reading the parallel [state and federal constitutional] clauses independently and affording broader protection, where appropriate, under the State Constitution." Judith S. Kaye, *Dual Constitutionalism in Practice and Principle*, 61 St. John's L. Rev. 399, 412 (1987). The authority of state courts to define state constitutional guarantees is an indispensable component of the federal structure of government. William J. Brennan, Jr., *State Constitutions and the Protection of Individual Rights*, 90 Harv. L. Rev. 489, 495-96 (1977); Sol Wachtler, *Our Constitutions — Alive and Well*, 61 St. John's L. Rev. 381 (1987); Vito J. Titone, *State Constitutional Interpretation: The Search for an Anchor in a Rough Sea*, 61 St. John's L. Rev. 431 (1987).

The New York Court of Appeals has previously suggested that the scope of New York's equal protection guarantee "is no more broad in coverage than its Federal prototype," the equal protection clause of the fourteenth amendment. *Esler v. Walters*, 56 N.Y.2d 306, 313-14 (1982) (quoting *Dorsey v. Stuyvesant Town Corp.*, 299 N.Y. 512, 530 (1949)). *See Under 21 v. City of New York*, 65 N.Y.2d 344, 360 n.6 (1985). The Court has reasoned that the language of the two provisions are nearly identical, and has also pointed to

> the fact that the chairman of the Bill of Rights Committee of the New York State Constitutional Convention of 1938, at which convention the section in question was approved, stated at the convention that the first sentence of section 11 "in effect embodies in our Constitution the provisions of the Federal Constitution which are already binding upon our State and its agencies." (2 Rev. Record of N.Y. State Constitutional Convention, 1938, p. 1065).

Dorsey, 299 N.Y. at 530. *See Under 21*, 65 N.Y.2d at 360 n.6.

Neither the identity in language between the federal and state equal protection clauses nor the intention of the 1938 Constitutional Convention to "embod[y]" in the State provision the guarantees of the federal equal protection clause prevents New York courts from interpreting the State provision in a manner that diverges from federal court interpretations of its federal counterpart, including those of the United States Supreme Court. New York courts are just as capable as federal courts of interpreting the text of the provision and the principle of equality underlying it. Any suggestion that New York courts must slavishly follow federal interpretations of the federal equal protection clause would be flatly inconsistent with the final authority of New York courts to decide questions of New York law. *See, e.g., Michigan v. Long*, 463 U.S. 1032 (1983). Simply put, were a New York

court to interpret "equal protection" to provide more protection in a given circumstance than has the United States Supreme Court, there would be no reason to assume that it was the New York court that erred.

In any event, the Court of Appeals has more recently indicated that it is not constrained by the bounds of federal equal protection. In determining that a Latino defendant's equal protection rights were not violated by the prosecution's use of peremptory challenges to exclude Spanish-speaking jurors who gave reason to believe that they would have difficulty accepting the official translator's version of the testimony of Spanish-speaking witnesses, the Court did not consider itself bound by the scope of the right recognized in *Batson v. Kentucky*, 476 U.S. 79 (1986). Instead, it observed merely that

> [its] analysis of the record and issues . . . on the merits would produce the same result under the Federal and State equal protection right, as no justification for breaking new ground as to this clause by differentiating between this dually protected constitutional right is sufficiently advanced.

People v. Hernandez, 75 N.Y.2d 350, 358 (1990) (citations omitted). *See also People v. Kern*, 75 N.Y.2d 638, 649 *cert. denied*, 111 S. Ct. 77 (1990).[5]

---

[5] The search and seizure provision of the New York State Constitution was also adopted by the 1938 Convention by appropriating the language of its federal counterpart, and its history is closely analogous to that of the New York equal protection section. *See* Kaye, *Dual Constitutionalism*, 61 St. John's L. Rev. at 416 n.60; *People v. P.J. Video, Inc.*, 68 N.Y.2d 296, 304 n.4 (1986), *cert. denied*, 479 U.S. 1091 (1987) (providing a brief history of N.Y. Const., art. I, § 12). Nevertheless, the New York Court of Appeals has frequently read the New York provision to offer greater protection than the federal. *See P.J. Video*, 68 N.Y.2d at 304; *People v. Johnson*, 66 N.Y.2d 398, 406 (1985); *People v. Bigelow*, 66 N.Y.2d 417, 427 (1985). For example, the Court has refused to engraft onto the New York guarantee the "so-called good faith exception to the warrant

(continued...)

"When weighed against the ability to protect fundamental constitutional rights, the practical need for uniformity can seldom be a decisive factor." *People v. P.J. Video, Inc.*, 68 N.Y.2d 296, 304 (1986), *cert. denied*, 479 U.S. 1091 (1987). Plainly, it remains open to New York citizens to establish that the New York guarantee of equal protection of the laws confers rights upon them that the United States Supreme Court has refused to recognize. A woman's right to receive state-funded, pregnancy-related medical benefits without regard to how she exercises her right to procreative choice is one such right.

B. Chapter 584 Violates The Equal Protection Clause Of The New York State Constitution.

1. The New York State Constitution Protects A Woman's Right to Procreative Choice.

Because in 1970 New York repealed its prohibition of first- and second-trimester abortions, New York courts have had little occasion to consider the right to procreative choice under the New York State Constitution. There can be no question, however, that, as the Supreme Court held below, the due process guarantee of section 6, article I, of the New York Constitution protects that fundamental right. *Hope v. Perales*, 571 N.Y.S.2d 972, 976-78 (Sup. Ct. N.Y. Co. 1991).

---

[5](...continued)
requirement" and the "'totality of the circumstances' test in warrant cases," even though the United States Supreme Court has applied them to the search and seizure protection of the federal fourth amendment. *P.J. Video*, 68 N.Y.2d at 304.

First, the New York Court of Appeals has expressly recognized that due process encompasses a right to privacy and individual autonomy in the realm of marriage, procreation, and contraception. *Matter of Doe v. Coughlin*, 71 N.Y.2d 48, 52, 53 (1987) (plurality opinion of Simons, J.), *cert. denied*, 488 U.S. 879 (1988); *id.* at 62 (Wachtler, C.J., concurring in result); *id.* at 63-65 (Alexander, J., dissenting). *See, e.g., Cooper v. Morin*, 49 N.Y.2d 69, 80-81 (1979) ("fundamental right to marriage and family life . . . and to bear and rear children" gives rise to prisoner's right to contact visitation under state, but not federal, due process guarantee), *cert. denied*, 464 U.S. 984 (1980). *See also Roe v. Wade*, 410 U.S. 113 (1973) (abortion); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (contraception); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (contraception); *Skinner v. Oklahoma*, 316 U.S. 535 (1942) (procreation). Given the critical importance of the decision whether to bear a child, the right to privacy must extend to the supremely personal realm of abortion. *See Matter of Doe*, 71 N.Y.2d at 63-64 (Alexander, J., dissenting); *Roe v. Wade*, 410 U.S. at 153; *Committee to Defend Reprod. Rights v. Myers*, 625 P.2d 779, 792-93 (Cal. 1981).

Second, New York has long recognized the importance of individual autonomy in medical decisionmaking and therefore guarantees all competent adults the right to make their own personal health care decisions free of state interference. *Fosmire v. Nicoleau*, 75 N.Y.2d 218, 231 (1990). This right is grounded in the common law, *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129 (1914) (Cardozo, J.) ("Every human being of adult years and sound mind has a right to determine what shall be done with his [or her] own

body."); in statutes, N.Y. Pub. Health Law §§ 2504, 2805-d (McKinney 1985 & Supp. 1991); and in the liberty interest protected by the due process clause of the New York Constitution, N.Y. Const. art. I, § 6; *Rivers v. Katz*, 67 N.Y.2d 485, 493 (1986).

In *Rivers v. Katz*, the Court of Appeals held that the common law right to control the course of one's medical treatment is "coextensive with the patient's liberty interest protected by the due process clause of [the New York] Constitution." *Id.* The Court reasoned that

> [i]n our system of a free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his [or her] medical treatment in order to insure that the greatest possible protection is accorded his [or her] autonomy and freedom from unwanted interference with the furtherance of his [or her] own desires.

Id. (citations omitted).

Pregnancy is a physical condition requiring medical care and treatment. *See Hope v. Perales*, 571 N.Y.S.2d at 980; *see also Moe v. Secretary of Admin.*, 417 N.E.2d 387, 402 (Mass. 1981) ("In every pregnancy, [either medical procedures for its termination, or medical procedures to bring the pregnancy to term are] medically necessary . . . .") (quoting *Harris v. McRae*, 448 U.S. 297, 333 (1980) (Brennan, J., dissenting) (brackets in the Massachusetts Supreme Court opinion)). And abortion is a medical procedure. *See Beal v. Doe*, 432 U.S. 438, 449 (1977) (Brennan, J., dissenting) ("[A]bortion and childbirth, when stripped of the sensitive moral arguments surrounding the abortion controversy, are simply two alternative medical methods of dealing with pregnancy . . . .") (quoting *Roe v. Norton*, 408 F. Supp. 660, 663 n.3 (D. Conn. 1975), *rev'd sub nom. Maher v. Roe*, 432 U.S. 464

(1977)). It follows that the decision whether to carry to term or abort is reinforced by the right to medical autonomy.

Plainly, pregnancy is a condition with enormous impact on a woman's health and well-being. *See supra* at 5-8. The available medical and scientific data reveal the numerous circumstances in which an abortion is medically necessary and the multitude of health risks brought on or aggravated by pregnancy and/or childbirth. These risks include increased chance of postpartum infection, severe hemorrhage, and psychological damage. *See supra* at 7. Where women suffer from preexisting medical conditions such as sickle-cell anemia, hypertension, diabetes, and cardiovascular disease, the risks to life because of pregnancy become even more pronounced. These women risk heart failure, severe hypertension, stroke, visual loss, and death. *See supra* at 8-11. Finally, even where carrying a pregnancy to term is not contraindicated, approximately twenty per cent of pregnancies carried to term terminate in major surgery by cesarian section. *See supra* at 7. In sum, few other medical conditions have such a profound effect on a person's mind and body or promise such a far-reaching transformation in one's life as pregnancy.

In the matter of procreative choice merge two components of the right to privacy — the right to personal autonomy in the sphere of childbearing, and the right of personal control over medical care. It is hence critical that in affording health-care benefits to a class of women that includes some who will require medically necessary abortions, the State fully respect a woman's choice whether to carry to term or abort.

2. Chapter 584 Impermissibly Discriminates in the Provision of Medical Benefits on the Basis of a Woman's Exercise of Her Right to Procreative Choice.

a. Chapter 584 is Subject to Strict Scrutiny Under the New York Equal Protection Clause.

Article I, Section 11 of the New York State Constitution, the equal protection provision, mandates "'that all persons similarly situated be treated alike.'" *Madole v. Barnes*, 20 N.Y.2d 169, 173 (1967) (quoting *Myer v. Myer*, 271 A.D. 465, 472 (1st Dep't 1946), *aff'd*, 296 N.Y. 979 (1947)). *See also Zaidens v. Village of Hastings-on-Hudson*, 567 N.Y.S.2d 801, 802 (2d Dep't 1991). Thus, if the State confers a benefit upon a specified category of individuals, the classification must "'rest upon some difference which bears a [legally sufficient relation to the subject] in respect to which the classification is proposed.'" *Madole*, 20 N.Y.2d at 173 (quoting *Myer*, 271 A.D. at 472). *See East Meadow Community Concerts Ass'n v. Board of Educ.*, 18 N.Y.2d 129, 133-34 (1966). *Accord Right to Choose v. Byrne*, 450 A.2d 925, 935 (N.J. 1982); *Moe v. Secretary of Admin.*, 417 N.E.2d 387, 401 (Mass. 1981) (vindicating "right to have abortions nondiscriminatorily funded") (quoting *Singleton v. Wulff*, 428 U.S 106, 118-19 n.7 (1976) (plurality opinion of Blackmun, J.); *Doe v. Director of Dep't of Social Services*, 468 N.W.2d 862, 877 (Mich. Ct. App. 1991) (state may not impose "unconstitutional substantive conditions" on the receipt of government benefits); *Harris v. McRae*, 448 U.S. 297, 349 (1980) (Stevens, J., dissenting) ("When the sovereign provides a special benefit or a special protection for a class of persons, it must

define the membership in the class by neutral criteria; it may not make special exceptions for reasons that are constitutionally insufficient.").

Following the two-tiered approach to equal protection developed by the United States Supreme Court, the New York Court of Appeals has held that

> [t]he threshold determination is whether the challenged provision establishes a classification which burdens [a fundamental right]. If it does, it must withstand strict scrutiny and is void unless necessary to promote a compelling State interest and narrowly tailored to achieve that purpose.

Golden v. Clark, 76 N.Y.2d 618, 623 (1990) (citing *Rosenstock v. Scaringe*, 40 N.Y.2d 563 (1976); *Alevy v. Downstate Medical Ctr.*, 39 N.Y.2d 326 (1976)). *Accord Memorial Hospital v. Maricopa County*, 415 U.S. 250, 258 (1978) (classification that operates to penalize those persons who exercise constitutional right must satisfy compelling state interest test); *Committee to Defend Reprod. Rights v. Myers*, 625 P.2d 779, 789, 793 n.22 (Cal. 1981) (California constitution requires that classification burdening fundamental right be necessary and narrowly tailored to accomplish compelling state interest). As the Supreme Court in this case properly held, a statutory scheme that distinguishes among putative beneficiaries depending on whether they exercise a woman's fundamental right to procreative choice must be strictly scrutinized.

b. Chapter 584 Penalizes the Exercise of the Fundamental Right to Procreative Choice by Denying Benefits to Eligible Women and Therefore Must be Strictly Scrutinized.

Chapter 584 is a comprehensive health-care program available to pregnant women whose income is between 100 and 185% of the federal poverty line. N.Y. Pub. Health Law §2521(3) (McKinney's Supp. 1992). The program provides pregnant women with funds for a wide range of prenatal care services "necessary to assure a healthy delivery and recovery," including mental health and related social services, labor and delivery services, post-partum services, inpatient care, dental services and emergency room services. *Id.* § 2522(1). However, the statute does not provide pregnant women funding for abortions and abortion-related services, even when necessary to preserve a woman's life or health.

Hence, Chapter 584 straightforwardly discriminates on the basis of a woman's exercise of her fundamental right to procreative choice. As the Michigan Court of Appeals recently explained with respect to a state Medicaid statute that embodied the same sort of classification at issue in this case:

> Plaintiffs are indigent women, otherwise qualified to receive the benefits of the Medicaid program. . . . If such a Medicaid-qualified pregnant woman exercises her fundamental right to bear her child, the state must, by statute, provide funding for her medically necessary care during her pregnancy. However, if such a woman chooses to have an abortion, even where medically necessary or required to terminate a pregnancy resulting from rape or incest, [the statute] directly prevents the state from providing funds for that care. It is the woman's exercise of one fundamental right — the right to an abortion — which triggers [the statute's] restrictions.

Doe v. Director of Dep't of Social Services, 468 N.W.2d at 876. *See also Committee to Defend Reprod. Rights v. Myers*, 625 P.2d at 780 ("[T]he constitutional question . . . does

not involve a weighing of the value of abortion as against childbirth, but instead concerns the protection of either procreative choice from discriminatory governmental treatment.").

The discrimination against the exercise of the right to procreative choice inherent in Chapter 584 constitutes a constitutionally cognizable burden mandating strict scrutiny. *See Madole v. Barnes*, 20 N.Y.2d 169, 173 (1967). Where a statute discriminates against the exercise of a fundamental right, the plaintiff need not show that the discriminatory restriction is a potent deterrent to the exercise of that right; "the compelling-state-interest test [is] triggered by 'any classification which serves to *penalize* the exercise of that right.'" *Dunn v. Blumstein*, 405 U.S. 330, 340 (1972) (quoting *Shapiro v. Thompson*, 394 U.S. 618, 634 (1969)). *See Right to Choose*, 450 A.2d at 934-37 (focusing on the discriminatory effect of the statutory ban on abortion funding rather than the magnitude of the actual burden on poor women); Lawrence H. Tribe, *American Constitutional Law* § 16-7 at 1454 (2d ed. 1988) (observing that while equal protection doctrine protects against classifications "structured in such a way as to deter or penalize the exercise of a right independently protected against governmental interference," the "penalization" referred to in the case law is largely, if not wholly, rhetorical).

In any event, the classification scheme indisputably has a substantial and critical impact on the excluded women. Chapter 584 makes benefits dependent upon a woman's choice of one of two courses of medical treatment available to pregnant women, denying funding for one, abortion, even where it is medically necessary. As the record in the trial court establishes, women thereby deterred from seeking or prevented from obtaining

medically necessary abortions face grave risks to life and health. Henshaw ¶ 7, A. 138; Crawley ¶ 9, A. 266. It also illustrates the tragic catch-22 in which poor pregnant women find themselves when they are denied abortion funding for which they are otherwise qualified: their search for funds to pay for the abortion causes delay, which increases the price for a later term abortion, which in turn places the procedure further out of reach. See Rosenfield ¶ 6, A. 166; Dumois ¶¶ 9-10, A. 211-12; Alexander ¶ 8, A. 225-26; Elahi ¶¶ 4-6, A. 248-50; Crawley ¶¶ 9-14, A. 266-69; Collier ¶¶ 5-10, A. 271-77; Romeo ¶¶ 7-11, A. 281-85; Rose ¶ 7, A. 288.

Clearly the threshold requirement of a penalty on the exercise of a fundamental right is met. *See Harris v. McRae*, 448 U.S. 297, 334 (1980) (Brennan, J., dissenting) ("[T]he discriminatory distribution of the benefits of governmental largesse can discourage the exercise of fundamental liberties just as effectively as can an outright denial of those rights through criminal and regulatory sanctions."); *id.* at 344 (Marshall, J., dissenting); *cf. Carey v. Population Servs. Int'l*, 431 U.S. 678, 715 (1977) (Stevens, J., concurring) ("[A]n attempt to persuade by inflicting harm . . . is . . . unacceptable."); *Moe v. Secretary of Admin.*, 417 N.E.2d at 400-01; *Right to Choose*, 450 A.2d at 935.[6]

---

[6] In an attempt to explain away this burden, the State contends that Chapter 584 does not penalize otherwise eligible women because they are "presumed" to be able to afford their own medical care and, accordingly, the statute does not burden their exercise of the fundamental right to obtain an abortion. Brief for Defendants-Appellants (December 13, 1991), at 35-42. To the contrary, a statute that discriminates against the exercise of a fundamental right need not be shown to substantially impair the exercise of that right, as the discrimination suffered itself constitutes an injury sufficient to render the statute

(continued...)

c. The Discrimination Inherent in Chapter 584 Cannot Be Justified By Any State Purpose.

Because Chapter 584 has a discriminatory impact on a woman's fundamental right to procreative choice, it violates the New York guarantee of equal protection unless the discriminatory classification serves a compelling state interest and is narrowly tailored to achieve its ends. *See Golden v. Clark*, 76 N.Y.2d 618, 623 (1990); *Rivers v. Katz*, 67 N.Y.2d 485, 489 (1986). The Supreme Court concluded correctly that Chapter 584 cannot withstand such scrutiny.

The State contends that Chapter 584 was enacted to provide adequate prenatal care in order to fight infant mortality and morbidity. While promoting the health and vitality of infants is undoubtedly an important state interest, the exclusion of those women seeking a medically necessary abortion in no way promotes that goal. *See Committee to Defend Reprod. Rights v. Myers*, 625 P.2d at 790. Depriving women who seek medically necessary abortions of funding for those abortions and related services in no way affects or compromises the health of women who carry to term and the children they bear. The State

---

[6](...continued)
constitutionally infirm. *See Madole*, 20 N.Y.2d at 173. Second, the State may not "presume" away a burden otherwise established. *See Maresca v. Cuomo*, 64 N.Y.2d 242, 250 (1984). Here, not only did plaintiffs establish in the Supreme Court the substantial impact of the denial of funding, *see Hope v. Perales*, 571 N.Y.S.2d at 978-79; *see also* A. 96-290 (affidavits submitted in support of plaintiffs' motion for an order to show cause), but the Legislature itself, in enacting the program, recognized that this class of women would not otherwise have meaningful access to the medical care the program provides. *Hope v. Perales*, 571 N.Y.S.2d at 975.

concedes as much by arguing that abortion need not be funded because it has no relation at all to neonatal health. But that argument misses the point. Even if the State has no obligation to fund abortions as a general matter, "once it chooses to enter the constitutionally protected area of choice, it must do so with genuine indifference." *Moe v. Secretary of Admin.*, 417 N.E. 2d at 402; *see Right to Choose*, 450 A.2d at 935. In short, the utter irrelevance of the disciminatory exclusion to the legislative goal prevents Chapter 584 from surviving even rational basis scrutiny, let alone strict scrutiny.

Second, the State could not in any event seek to advance its interest in infant health at the expense of women's health. *See Roe v. Wade*, 410 U.S. 113, 163-65 (1973); *Committee to Defend Reprod. Rights v. Myers*, 625 P.2d at 795 (holding that the State could not lawfully assert "an interest in protecting a fetus vis-a-vis the woman of whom the fetus is an integral part . . . [which] clashes head-on with the woman's own fundamental right of procreative choice"); *Right to Choose*, 450 A.2d at 935-37 ("A woman's right to choose to protect her health by terminating her pregnancy outweighs the State's asserted interest in protecting a potential life at the expense of her health."); *Doe v. Director of Dep't of Social Services*, 468 N.W.2d at 877; *cf. Planned Parenthood Ass'n v. Department of Human Resources*, 663 P.2d 1247, 1260 (Or. Ct. App. 1983) ("*Wade* established that the state's interest in protecting potential life during the first two trimesters is no greater than the mother's interest in protecting her health."); *Harris v. McRae*, 448 U.S. 297, 351 (1980) (Stevens, J., dissenting) ("If a woman has a constitutional right to place a higher value on avoiding either serious harm to her own health or perhaps an abnormal childbirth than on

protecting potential life, the exercise of that right cannot provide the basis for the denial of a benefit to which she would otherwise be entitled.") (footnote omitted).

d. Chapter 584 Violates Equal Protection.

Chapter 584 provides needy women funding for pregnancy-related medical treatment, but discriminates against those seeking a medically necessary abortion:

> [Plaintiffs] have met the statutory requirements for eligibility, but they are excluded because the treatment that is medically necessary involves the exercise of a fundamental right, the right to choose an abortion. In short, [plaintiffs] have been deprived of a governmental benefit for which they are otherwise eligible, solely because they have attempted to exercise a constitutional right.

Harris v. McRae, 448 U.S. at 345-46 (Marshall, J., dissenting). At the same time, the exclusion of these women does nothing to promote neonatal health, the state's asserted goal. Hence, as the Supreme Court held, Chapter 584 fails strict scrutiny review and violates the New York guarantee of equal protection of the laws. Its decision comports with a series of decisions from courts in other states that have invalidated similar exclusions. See *Doe v. Director of Dep't of Social Services*, 468 N.W.2d at 869-73, 880 (equal protection clause of Michigan constitution); *Right to Choose*, 450 A.2d at 934-37 (equal protection clause of New Jersey constitution); *Committee to Defend Reprod. Rights v. Myers*, 625 P.2d at 793 n.22 (California constitution's equal protection guarantee); *Doe v. Maher*, 515 A.2d 134, 157-62 (Conn. Super. Ct. 1986) (equal protection clause of Connecticut constitution); *Moe v. Secretary of Admin.*, 417 N.E.2d at 399-402 (due process clause of Massachusetts constitution); *cf. Planned Parenthood Ass'n v. Department of Human Resources*, 663 P.2d at 1256-61

(denial of funding for abortion under a statute granting prenatal health care benefits violated the State's Equal Privileges and Immunities Clause which "prevent[s] the enlargement of the rights of some in discrimination against the rights of others"). *Contra Fischer v. Department of Public Welfare*, 502 A.2d 114 (Pa. 1985) (finding no fundamental right to an abortion).

C. Chapter 584 Also Violates The Requirement That Assistance To The Needy Not Be Distributed On A Basis Other Than Need.

The New York Constitution charges the Legislature with the task of identifying the needy and providing appropriate relief. "In New York State, the provision for assistance to the needy is not a matter of legislative grace; rather, it is specifically mandated by our Constitution." *Tucker v. Toia*, 43 N.Y.2d 1, 7 (1977). The Constitution declares:

> The aid, care and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions, and in such manner and by such means, as the legislature may from time to time determine.

N.Y. Const., art. XVII, § 1.

The New York Court of Appeals has interpreted this provision to give the Legislature discretion in determining who is "needy"; in determining the means of providing aid, care and support; and in setting the amount of aid. *Tucker*, 43 N.Y.2d at 8. This constitutional provision, however, "unequivocally prevents the Legislature from simply refusing to aid those whom it has classified as needy." *Id.* *See Bernstein v. Toia*, 43 N.Y.2d 437, 448-49 (1977); *Barie v. Lavine*, 40 N.Y.2d 565, 570 (1976).

In enacting Chapter 584, the Legislature has identified a class of needy individuals: pregnant women whose income is between 100 and 185 percent of the poverty line. But in refusing to provide funds for abortion services, the Legislature impermissibly denied aid to some of those needy solely on the basis of how they exercise their right to procreative choice — plainly a criterion wholly unrelated to need. The State has thereby made an irrelevant and constitutionally impermissible distinction among those who should receive medical assistance and violated the explicit mandate of article XVII, section 1 of New York Constitution.

V.

CONCLUSION

For the foregoing reasons, as well as those set forth by Plaintiffs-Respondents, the decision of the Supreme Court should be affirmed.

Dated: New York, New York
February 3, 1992

Respectfully submitted,

DEBEVOISE & PLIMPTON
875 Third Avenue
New York, New York 10022

Attorneys for *Amici Curiae*

Of Counsel:
Donald Francis Donovan
Christopher A. Murphy
Jennifer K. Weidman
Kathleen M. Conkey

APPENDIX

INDIVIDUAL DESCRIPTIONS OF *AMICI CURIAE*

The American College of Obstetricians and Gynecologists ("ACOG") is the leading group of professionals providing health care for women. Its membership numbers more than 25,000 physicians specializing in obstetric-gynecologic care (approximately 90 percent of those in the field). A non-profit organization established in 1951, ACOG serves as a strong advocate for quality health care for women, maintains the highest standards of clinical practice and continuing education for its members, promotes patient education and involvement in medical care and works to increase member and public awareness of the changing issues facing women's health care. Through four decades, ACOG has been a leader in helping to make dramatic improvements possible in the entire field of women's health care.

District II, the New York Office of ACOG, was established in 1986 and serves New York State. A proportionately high number ACOG members -- approximately 2,200 -- practice in New York. District II strives to maintain excellence in obstetrics and gynecology and to make adequate health care available to underserved women.

The American Foundation for AIDS Research ("AmFAR") is a private, not-for-profit organization dedicated to mobilizing the goodwill, energy and generosity of Americans and people throughout the world to end the HIV/AIDS epidemic. AmFAR is the leading national non-profit organization devoted to AIDS research. Since 1985, AmFAR has provided more

than $39 million to 620 innovative research, education and public policy projects to fight HIV/AIDS and improve health care.

American Medical Women's Association ("AMWA") is a nonprofit organization of 11,000 women physicians and medical students. One of AMWA's primary missions is to promote quality health care for women. AMWA strongly supports laws which protect the health of women, particularly the right of the pregnant patient, in consultation with her physician, to make a personal and medically informed decision whether or not to continue a pregnancy.

The American Public Health Association ("APHA") is a national organization devoted to the promotion and protection of personal and environmental health and to disease prevention. Founded in 1872, APHA is the largest public health organization in the world, with over 50,000 members. It represents all disciplines and specialties in public health, including patients and health professionals such as physicians, nurses, health educators and family planning specialists.

Benedict Health Center serves Saratoga County and the surrounding community. As a PCAP provider, the Center serves 350 prenatal patients a year, a high proportion of whom are low-income women. The Center strongly believes in the right to privacy and safe, reproductive options for all its clients.

Choices Women's Medical Center, Inc. was founded in 1971 to serve the Health Insurance Plan of Greater New York as an out-patient abortion facility. It has become one of the leading and largest feminist medical centers in the country, serving more than 35,000

services, including but not limited to abortion, and infant and maternal nutrition and health care. The Fund supports nutrition, family planning and abortion services in many parts of Africa and Asia and abortion law reform in the United States.

The Jamaica Hospital is a 317-bed voluntary, not-for-profit community hospital that serves southeastern Queens. The Hospital is designated as a PCAP provider and offers a full range of comprehensive services for women who are enrolled in this program. The Jamaica Hospital supports the right of pregnant women to make decisions about their medical care.

The Long Island College Hospital is a 567-bed acute care hospital located in Brooklyn. The institution affirms the right of all women to have safe and comprehensive reproductive health care. It further believes that decisions concerning reproductive health care are personal ones, and that the right to make informed decisions should be available to all women.

The National Association of Social Workers, Inc. ("NASW"), a nonprofit professional association with more than 135,000 members, is the largest such organization in the United States. The New York State Chapter has more than 10,500 members and the New York City Chapter has more than 8,800 members. NASW believes that all individuals should be free to make decisions about their medical care without state interference and that the state should not override a pregnant woman's autonomy nor restrict her right to choose abortion.

The New York Gray Panthers, founded in 1982, is a network of the National Organization. The Gray Panthers are against any form of discrimination and cannot condone any diminution of the rights of an individual in a free society.

Pathfinder International, founded in 1957, is dedicated to ensuring the availability of family planning services throughout the developing world. Its activities include exploring new service delivery mechanisms, local institution building, training family planning providers and providing contraceptive supplies. In both the United States and overseas, Pathfinder addresses public policy issues that affect the availability of safe and effective family planning services.

Planned Parenthood of the Finger Lakes, a chapter of the national institution, works in the Finger Lakes region to support sexuality education and access to birth control, to promote medical research in the areas of birth control and reproductive health and to secure the right of all women to obtain safe and legal abortions.

Planned Parenthood Health Services of Northeastern New York, Inc. believes that it is the right of each woman to control her own fertility. This is only possible through universal access to quality reproductive health care services, including support for both abstinence and contraception, as well as parenthood, adoption and abortion. The organization offers confidential services to any woman of childbearing age -- rich and poor, mothers and daughters, single and married women alike -- and to their partners.

Planned Parenthood of Nassau County, Inc. ("PPNC") has provided family planning services to the residents of Nassau County and surrounding areas for over 50 years. As a recent authorized PCAP provider, PPNC is troubled by the exclusion of funds for abortion services in PCAP, which must allow a poor woman to access the health care system for whatever course she decides is in her best interest.

St. Luke's-Roosevelt Hospital Center ("SLRHC") is a voluntary, not-for-profit hospital corporation serving New York City from West 34th Street to West 142nd Street, an area with a population of a half-million people who are generally older, poorer and sicker than that of the Borough, City or State as a whole. SLRHC has over 140 hospital and community-based clinics, to which almost 400,000 visits are made annually. It runs PCAP programs at both its West 59th Street and 114th Street sites.

Segundo Ruiz Belvis Neighborhood Family Care Center serves mostly medically indigent women of childbearing age in the South Bronx. The Center provides counseling on the use of contraceptives, among other services. It strongly supports the fundamental right of its clients to choose the outcome of their pregnancies.

Womancare Clinic is a nonprofit organization founded 19 years ago. It provides gynecological services, including abortion, to 10,000 women of reproductive age in San Diego County per year. Most clients are working and poor, only some of whom qualify for Medi-Cal. Womancare's experience shows that poor women who want to terminate a pregnancy, but cannot get subsidized abortion services, will still opt for abortion, but must undergo later procedures that are riskier and costlier. Some, unable to afford later procedures, will carry an unwanted pregnancy to term.

Women's Health Education Project is a nonprofit organization that provides self-help and preventive health care information to low-income women, especially those in homeless and battered women's shelters. The Project supports a woman's right to choose what is best for her and her pregnancy and wants to ensure that women who choose not to continue a

pregnancy receive as much economic support from the State for that decision as those who decide to carry a pregnancy to term.

The Women's Medical Association of New York City ("WMA-NYC") is a private, voluntary, professional association of women physicians living and/or practicing in New York. It is a chapter of the American Women's Medical Association. WMA-NYC has repeatedly taken the position that access to abortion is a health issue and that financial and other barriers should not influence a woman's decision in having or not having an abortion.

YWCA of Brooklyn has long been concerned about women's health issues, including the quality of services, the right of a woman to be informed about legal options and the right of an individual to make her own decisions privately, with her physician's guidance, based on her own religious and ethical values. The YWCA supports the rights of all women to privacy and to equal access to health care and reproductive services and opposes policies that disproportionately affect women of color.