

## Rights Without Access: Revisiting Public Funding Of Abortion for Poor Women

*Declarations made this year in the course of the presidential campaign have given new hope to advocates who have long been frustrated in their attempts to ensure that women at all income levels have the ability to exercise their constitutional right to choose abortion. These advocates decry the practical impact of the so-called Hyde Amendment, measured both in the sacrifices of women who struggle to find another source of funds for an abortion and in the births to those unable to do so. This impact is only compounded, they say, by the meager and diminishing level of government support for low-income mothers in the post-welfare reform era.*

**By Heather Boonstra and Adam Sonfield**

After years languishing on the political back burner, the issue of public funding of abortion for poor women was brought into focus this winter by debates between the Democratic presidential hopefuls. Seeking to reconcile his prior opposition to Medicaid funding except in the rarest and most extreme circumstances with statements that he has “always been prochoice,” Vice President Al Gore explained his antifunding stance during the late 1970s and early 1980s as consistent with the majority opinion in Congress to “keep the government completely out of it” in deference to taxpayers opposed to abortion. Over time, he said, he came to realize that prohibitions on abortion funding carried “an inequitable result” and denied poor women “the practical ability” to exercise their right to abortion.

Vice President Gore’s explicit acknowledgment that to be fully prochoice means working both to guarantee the legal right to abortion and to secure women’s real-world ability to access abortion services is heartening to advocates of poor women’s reproductive rights and health. Fully aware of the uphill nature of the battle, key groups are embarking on a renewed campaign for poor women’s abortion rights and reproductive equity.

### Two Decades of Restrictions

The political debate over Medicaid funding has been waged with varying intensity for a quarter of a century. The first version of the Hyde Amendment, named after Rep. Henry Hyde (R-IL), went into effect in August 1977. It forbade the expenditure of federal funds for abortion services, except in cases where the continuation of the pregnancy threatened the woman’s life, under all programs administered by the Department of Health, Education and Welfare (now the Department of Health and Human Services). The measure primarily affected Medicaid (Title XIX of the Social Security Act), the program under which the federal and state governments share the cost of necessary medical and surgical care for many of the poorest Americans, in particular women who receive welfare benefits on behalf of their children.

Congress has renewed the Hyde Amendment every year since, albeit with some modifications. In the early years, the annual debates were protracted and intense. In 1978, the standard was liberalized somewhat to include exceptions for “promptly reported” rape and incest and “severe and long-lasting physical health damage” confirmed by two physicians—a health exception far narrower than the standard set in 1973 by the U.S. Supreme Court in *Doe v. Bolton*, which clarified that in the context of abortion, “health” must be broadly defined to include both physical and mental health concerns. In 1979, the limited physical health exception was dropped, and the rape and incest exceptions were eliminated during the first year of the Reagan administration in 1981. While these policy changes did have some practical effect, federal funding of abortion under each of these policies was a mere fraction of the funding from pre-Hyde years.

It was not until the Clinton administration came to power that debate over the Hyde Amendment once again was joined. Even then, the restrictions were eased only slightly to allow funding for abortion in cases of rape and

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incest, as well as for life endangerment. And even that minor liberalization was short-lived. The current version of the Hyde Amendment, enacted in 1997, tightens the life exception to permit payment only when the woman’s life is threatened by “a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself.” It also provides that these restrictions be included in any Medicaid managed care benefits package funded with federal dollars; states funding abortions in

circumstances beyond those allowed by the Hyde Amendment must contract separately with their participating managed care plans for such services.

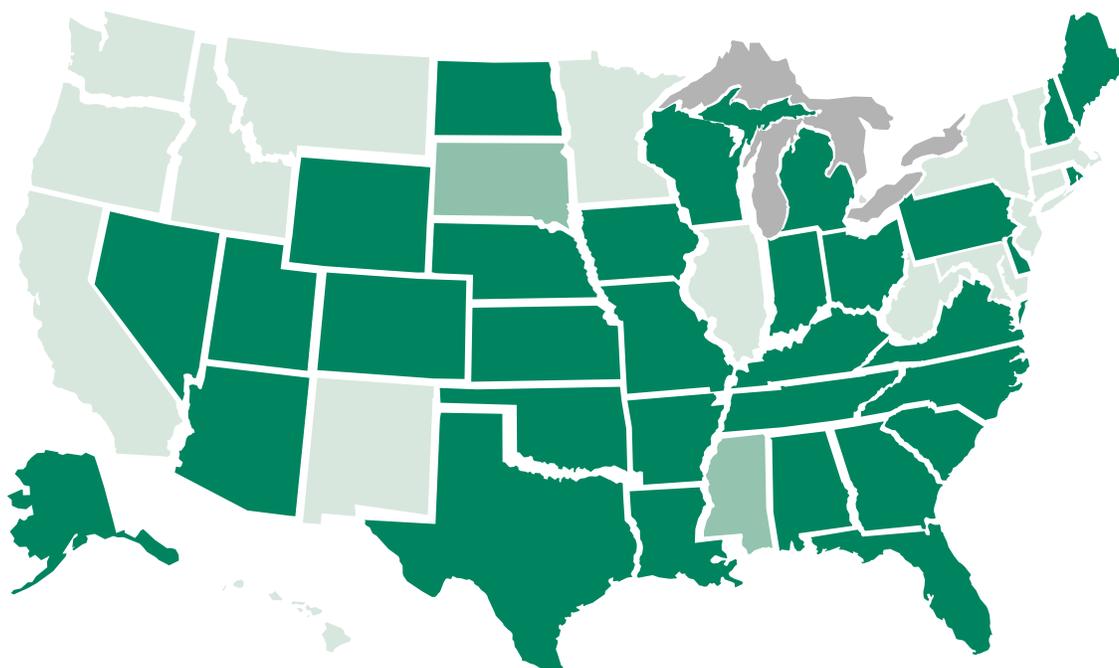
[Over the past two decades, Congress has enacted similar bans—as part of annual appropriations measures or within permanent law—in an effort to apply the antiabortion policy consistently throughout the range of federal programs. Today, these restrictions affect the health care of military personnel and their dependents, federal employees and their dependents, teenagers participating in the State Children’s Health Insurance Program, low-income residents of the District of Columbia, members of the Peace Corps, federal prison inmates and Native Americans, among others.]

At least at the federal level, challenges to the legality of the Hyde Amendment were put to rest 20 years ago. In June 1980, the Supreme Court held in *Harris v. McRae* that under the U.S. Constitution, the federal and state governments have no obligation to provide funds for the exercise of the right to abortion even when they pay for prenatal and maternity care for poor women. The federal government could choose to “encourage childbirth over abortion” by paying for the former and not the latter—even if, as Justice Potter Stewart suggested in the Court’s majority opinion, to do so might not be “wise social policy.”

At the state level, the issue has been somewhat more fluid. Currently 16 states (see map) have a policy to use their own funds to pay for all or most medically necessary abortions (those necessary to protect a woman’s health, under the broad definition in *Doe*) sought by Medicaid recipients—a list that has fluctuated substantially over the past 25 years. Of these states, four—Hawaii, Maryland, New York and Washington—adopted such a policy voluntarily. The remainder were ordered by their courts under their individual state constitutions to reverse policies that allowed payment for abortion only in the most limited of circumstances.

Most of the other 34 states are paying for abortions in those circumstances permitted under the federal Hyde Amendment, in line with the Medicaid statute’s requirement that states share in the funding of any service that meets the standards for federal coverage. Yet the 1993 easing of the Hyde Amendment was initially marked by erratic implementation across the country, including outright defiance by at least 11 states that eventually complied with federal court orders rather than risk the loss of Medicaid funds. Mississippi and South Dakota, which have not been sued over their policies, are the only states currently funding abortion only in cases of life endangerment, in violation of the federal statute.

## STATE POLICIES ON PUBLIC FUNDING OF ABORTION



■	IN CASES OF LIFE ENDANGERMENT ONLY	(2)
■	IN CASES OF LIFE ENDANGERMENT, RAPE AND INCEST	(32)
■	WHEN MEDICALLY NECESSARY	(16)

## Measuring the Impact

Six million women of reproductive age obtain health care through the Medicaid system. How are they affected by restrictions on public funding of abortion?

One of the first concerns immediately following the Hyde Amendment's initial implementation was whether large numbers of poor women would resort to illegal or self-induced abortions as a result of the public policy change. Indeed, a 1979 study by the Center for Disease Control (currently the Federal Centers for Disease Control and Prevention) linked four deaths to the unavailability of Medicaid funding. But while these deaths were tragic and unnecessary, the relatively small number suggested that there was little demographic impact from recourse to illegal or self-induced abortion.

Other studies set out to determine the importance of Medicaid funding for abortions on pregnancy outcomes. The results show, with little exception, that restrictions on funding have considerable impact on women's reproductive decisions. In the absence of funding, a significant percentage of pregnancies that would have otherwise been aborted are instead carried to term. An analysis by researchers at Princeton University's Office of Population Research and The Alan Guttmacher Institute (AGI) of the number of abortions to Medicaid-eligible women in two states before and after the law was enforced in the late 1970s, concluded that about 20% of the women who would have obtained an abortion had funding been available were unable to do so in the post-Hyde period and carried their pregnancy to term.

Two more recent studies also have found considerable impact. A 1994–1995 AGI survey of abortion patients found that in states where Medicaid pays for abortions, women covered by Medicaid have an abortion rate 3.9 times that of women who are not covered, while in

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states that do not permit Medicaid funding for abortions, Medicaid recipients are only 1.6 times as likely as nonrecipients to have abortions. In explaining this finding, the researchers state that while other factors also may be at play, “the magnitude of the difference indicates that Medicaid coverage of abortion has an important effect on the ability of poor women to end unwanted pregnancies.” Meanwhile, a study published by the *Journal of Health Economics* in 1999 considered the effects of interruptions in abortion funding in North Carolina (which paid for abortion until 1995). In five instances between 1978 and 1993, the state's abortion

fund was depleted before the end of the fiscal year. During those times when funding was not available, the researchers found, more than one in three women (37%) who would have obtained an abortion if the state had paid for it instead carried the pregnancy to term.

Studies also have found that women who are able to raise the money needed for an abortion do so at a great sacrifice to themselves and their families. In 1983, AGI researchers interviewed Medicaid-eligible patients having abortions to determine how they went about raising the money for the procedure and found that women were often forced to divert money that would otherwise be used to pay their daily expenses. Some said they used money that should have been spent on rent, utility bills, food and clothing for themselves and their children. Some even resorted to pawning household goods, theft or prostitution in a desperate effort to come up with the necessary cash. Little wonder that this study found that nearly 60% of Medicaid recipients said that paying for the abortion entailed serious hardship, compared with only 26% of non-Medicaid-eligible women.

Research also indicates that while many women may be able to ultimately scrape together the funds, the time this effort takes increases the delay between the decision to have an abortion and actually having the procedure. The 1983 AGI study found that Medicaid-eligible women wait on average 2–3 weeks longer than other women to have an abortion because of difficulties they have in obtaining the necessary funds. The cost of an abortion, of course, increases the longer a woman waits to have the procedure, exacerbating her difficulties. While the average cost of a first-trimester nonhospital abortion in 1997 was \$316, the charge jumped to \$618 at 16 weeks of gestation and the charge more than tripled to \$1,109 at 20 weeks. Such delays also can have health implications, because the risk of complications following an induced abortion increases as the procedure is done later in gestation.

Funding restrictions not only force some women to carry their pregnancy to term and others to wait longer before having an abortion. They also cost taxpayers millions of dollars annually in medical and other costs. Both prochoice and antiabortion supporters have traditionally shied away from discussing Medicaid coverage for abortion from a monetary perspective; nevertheless, the macroeconomic implications of government pressure on poor women not to have an abortion are real. At the most basic level, the cost to the taxpayer of subsidizing a first-trimester nonhospital abortion will always be far less than the cost of subsidizing prenatal and delivery services—not to mention the secondary costs of an unwanted birth, including the additional time a woman spends on Medicaid while struggling to provide for her family and obtain self-sufficiency.

## Restoring Medicaid Coverage

Although the decision in *Harris v. McRae* may have settled for the time being the federal constitutional question of whether federal policymakers *may* effectively deny many low-income women the means to exercise their constitutional right to an abortion, legislators and advocates at the federal and the state levels have continued to question whether government *should*, in essence, put its conscience above the health, well-being and conscience of its citizens. The Campaign for Access and Reproductive Equity, currently in formation, is being organized with a primary purpose of bringing the perspectives of poor and low-income women, young women and women of color to the debate about reproductive freedom and choice.

Spearheaded by the National Network of Abortion Funds (NNAF) and including traditional prochoice groups as well as a broader range of women's rights organizations, the Campaign—which officially will be launched this spring as a two-year, grassroots public education initiative—will work to convince legislators, judges and the general public that poor women deserve the same reproductive rights as those who are more fortunate. But Campaign organizers themselves are quick to acknowledge that overturning restrictions on abortion funding will be an uphill battle. The attention brought to these issues by the presidential campaign has provided an important rhetorical opening for this push, organizers say, but whether it will result in real policy change remains to be seen.

Campaign supporters will seek not only to highlight the

fundamental injustice of the Hyde Amendment and its progeny, but also to place these restrictions in the context of other policies that impede poor women's ability to care for themselves and their families. By singling out abortion for exclusion, says Marlene Gerber Fried of NNAF, government creates a two-tiered system of health care in which poor and low-income women do not have the same freedom to make their own decisions as those who can afford abortion or who are covered by private insurance. "It is fundamentally unjust and discriminatory for the government to deny women on Medicaid the same reproductive health options as women with the economic means," says Fried. Moreover, the impact

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of restrictions on Medicaid funding for abortion is only compounded by welfare reform requirements for poor families. Welfare provisions such as mandated work hours, time limits on child care subsidies, "family caps" that deny additional benefits for another child and paternity proof requirements, Fried says, punish poor and low-income women who give birth, making real reproductive choice a privilege of those who can afford it, rather than a fundamental right. "In the year 2000," Fried continues, "the right to choose, in its fullest sense, is an empty promise for thousands of poor and low-income women." ☉