



Discriminatory Restrictions on Abortion Funding Threaten Women's Health

Each year Congress passes a set of 12 appropriations bills, which collectively fund government programs from October 1 of one year to September 30 of the next. Anti-choice legislators have continually used these "must-pass" bills as vehicles to deny coverage for abortion services to millions of women whose health care is subject to federal control. Amendments to appropriations bills can restrict abortion coverage for: federal employees and their dependents; residents of the District of Columbia; low-income women and some disabled women who rely on Medicaid and Medicare for their health-care coverage; military personnel and their dependents; Peace Corps volunteers; Native-American women; and women in federal prisons. Similarly, attempts have even been made to restrict funds for women receiving medical care at family-planning clinics funded by the Title X program, the only federal program exclusively dedicated to family planning and reproductive-health services.

Funding Bans Are Discriminatory and Endanger Women's Health

Unable to make all abortion illegal, anti-choice legislators have tried to make abortion services nearly impossible for women to obtain by imposing multiple restrictions on the right to choose. They have used the appropriations process to impose bans on the use of federal funds for abortion care in most situations. In other circumstances, they have imposed broad restrictions on how these funds may be used. For example, the federal Hyde amendment prohibits the use of public funds for abortion services unless the procedure is necessary to save the woman's life or if the pregnancy is the result of rape or incest.

Lawmakers have also singled out abortion services for exclusion from federal health-care plans that cover other pregnancy-related care, jeopardizing women's health and discriminating against low-income women and women in public service. These restrictions impose significant, and in some cases insurmountable, obstacles to a woman's ability to exercise her constitutionally protected right to choose.

- Low-income women often have difficulty raising the money to pay for abortion care and, according to one study, on average need twice as much time to raise the necessary funds than do middle- or upper-income women.¹ These burdens disproportionately affect women of color, who, because of the connection between racial discrimination and economic disadvantages, are more likely than white women to be poor, to lack health insurance, and to rely on government health-care programs or plans.²

- According to the American Medical Association, federal funding restrictions that deter or delay women from seeking early abortion care make it more likely that women will bear unwanted children, continue a potentially health-threatening pregnancy to term, or undergo abortion procedures that could endanger their health.³
- A study by the Guttmacher Institute shows that Medicaid-eligible women in states that exclude abortion coverage have abortion rates of about half of those of women in states that fund abortion care.⁴ This suggests that the Hyde amendment forces about half the women who would otherwise choose abortion to carry unintended pregnancies to term and bear children against their wishes.
- Many women delay abortion services because they do not have the money to pay for the procedure. Almost half of the women who obtain abortion care after 15 weeks of pregnancy were delayed by problems obtaining the procedure — either raising the money or accessing a provider.⁵ Abortion care after the first trimester of pregnancy is more complicated and expensive, and there are far fewer providers who at that stage.⁶ Ironically, anti-choice advocates are themselves partly to blame for the need for later abortion because they have worked to deny women necessary funds to obtain earlier care.

Appropriations Bills and Abortion Restrictions

Labor, Health and Human Services, and Education

Medicaid - The Hyde Amendment

Title XIX of the Social Security Act authorizes the Medicaid program, which provides for the use of federal and state funds for medical care, including necessary health care related to pregnancy, for low-income individuals. Absent restrictive language included in the appropriation bill, Medicaid pays for "medically necessary" services, including abortion care. In 2006, more than one in three low-income women of child-bearing age looked to Medicaid for health care.⁷

However, since 1977, restrictions on the use of federal Medicaid funds for abortion services have been imposed through the Hyde amendment, attached to the annual Labor, Health and Human Services, and Education appropriations bill. From 1981 until 1993, the Hyde amendment prohibited federal Medicaid dollars from being used to provide abortion services except to preserve the woman's life. In 1993, the exception was expanded to include situations where the pregnancy resulted from rape or incest. In 1997, Congress adopted language to make it clear that the Hyde amendment applies to Medicaid recipients enrolled in managed care plans. In addition, Congress passed a permanent Hyde amendment in the Budget Reconciliation Act of 1997, which applies to the State Children's Health Insurance Program.

When Congress expanded federal Medicaid funding for abortion care for rape and incest victims in 1993, more than one-third of the states initially refused to comply with the federal law. Eleven states were ordered into compliance by federal courts. Every court that has considered the revised Hyde amendment has found that states that participate in the Medicaid program must cover abortion services in cases of rape or incest regardless of state laws that are more restrictive. South Dakota is currently not in compliance with Hyde requirements.⁸

With their own dollars, states may choose to fund abortion care for low-income women in more circumstances than the federal government allows. Currently, 17 states fund abortion services beyond the limitations of the Hyde amendment.⁹ In 13 of these states, courts have ruled that their state constitutions prohibit the exclusion of medically necessary abortion care from medical-assistance programs.¹⁰ The other states fund abortion services beyond the restrictions of the Hyde amendment either through legislation or executive branch policy.

Today, nearly 50 percent of Medicaid enrollees are people of color.¹¹ While most people receiving health care through Medicaid are white, people of color are overrepresented among Medicaid recipients with respect to their proportion of the general population. That women of color are more likely to be poor and without other health insurance can be understood in the context of the economic legacy of racism and overtly racist historic policies that influenced social status. Recognizing this connection and the impact of the Hyde amendment on the reproductive rights of women of color, a number of organizations representing these communities have campaigned on a civil-rights basis to lift the discriminatory ban on the use of public funds for abortion care.¹²

Medicare - The Hyde Amendment

Title XVIII of the Social Security Act establishes the Medicare program. Although Medicare primarily provides health services for the elderly, who have no need for abortion services, it also funds care for certain disabled persons, those with end-stage renal disease,¹³ and those who have received Social Security Disability Insurance for at least two years.¹⁴

In 1998, Congress applied the Hyde amendment to Medicare, banning publicly funded abortion care for disabled women except in cases of life endangerment, rape, or incest. Unlike the joint state/federal Medicaid program, Medicare is funded solely by the federal government. Thus, Medicare beneficiaries in every state are now denied their only source of public funding for abortion services.

The extension of the Hyde amendment to Medicare seriously jeopardizes the health of the nation's most vulnerable women. Many Medicare-eligible women have disabilities that significantly increase the risks associated with pregnancy, including cancer, rheumatic fever, severe diabetes, malnutrition, phlebitis, sickle cell anemia, and heart

disease.¹⁵ In addition, pregnancy can aggravate already existing disabilities such as hypertension, which, if not controlled, may cause convulsions and even death.¹⁶

Disabled women also face unique obstacles in obtaining access to abortion care. Women receiving Medicare are often too ill to hold a job in the economy, and thus may have extreme difficulty raising funds for abortion services. Moreover, 87 percent of U.S. counties lack an abortion provider,¹⁷ and the burdens of traveling for care may be particularly difficult for Medicare beneficiaries, especially when faced with increased, even grave, health risks. Some clinics and doctors' offices may decline to serve persons with health complications; at the same time, hospitals are often precluded by state laws or religious directives from offering abortion services.

Indian Health Service

The Department of Health and Human Services provides funding for the Indian Health Service (IHS) facilities, the health service delivery system for approximately 1.5 million American Indians and Alaska Natives.¹⁸ For many Native-American women living on or near reservations, IHS facilities are the only available medical care within hundreds of miles. From 1988 until 1993, the authorizing legislation prohibited these facilities from providing abortion services unless the woman's life was endangered, even if she paid for the procedure herself. Today, the authorizing legislation requires IHS to follow the federal Medicaid restrictions with regard to abortion funding. Consequently, when Labor/HHS modified the Hyde amendment restrictions on Medicaid to include abortion funding for rape and incest survivors in 1993, the IHS restrictions were also expanded. Despite these exceptions, obtaining even Hyde-permissible abortion care is nearly impossible because of the remote locations of most reservations and the lack of abortion facilities within the IHS system.¹⁹ The effects of this funding restriction combine with these barriers rendering effectively meaningless the right to choose for Native-American women who rely on IHS for their health care.

Defense

Military Personnel

The military offers health-care coverage to military personnel, retirees, and dependents through the TRICARE program (formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)). More than nine million people are eligible to receive health care through the military.²⁰ This program is funded through the Department of Defense appropriations bill. The authorizing legislation, which is approved yearly, has included a number of abortion funding restrictions since 1979. The Department of Defense is prohibited from providing any abortion coverage except in cases where the life of the woman is endangered. This ban was made permanent in the FY'85 authorizing legislation.

In 1988, the Department of Defense issued an administrative order prohibiting women from obtaining abortion services with their own private funds at military facilities overseas. President Clinton lifted this prohibition by executive order in January 1993.²¹ However, in 1995, anti-choice lawmakers reversed President Clinton's executive order by passing a Department of Defense appropriations bill that prohibited women from obtaining privately funded abortion services at overseas military facilities except in cases of rape or incest. Later that year this restriction was written into permanent law.

These restrictions discriminate against women who have volunteered to serve their country and deprive them of coverage they would otherwise receive through the majority of private sector insurance plans.²² Women who are stationed overseas are totally dependent on their base hospitals for medical care and should not be denied abortion services when confronted with an unintended pregnancy.

In recent years pro-choice lawmakers have proposed amendments to the annual Defense authorization bill to allow military personnel and their family members serving overseas to obtain abortion services at military hospitals using their own funds. The amendment would not provide for the use federal funds nor would it require doctors to provide abortions against their will; rather it would have allowed women to use private funds for abortion services in military hospitals. Unfortunately, anti-choice lawmakers have routinely defeated the proposal.²³

Foreign Operations

Peace Corps Volunteers

The Peace Corps program is funded through the Foreign Operations appropriations bill. Of the 7,876 U.S. citizens who are volunteers and trainees for the Peace Corps, 60 percent are women.²⁴ The program provides health-care coverage to its volunteers and trainees, but since 1979, the authorizing legislation has prohibited the use of funds to provide abortion services for volunteers and trainees, *even in cases where a woman's life would be endangered by carrying the pregnancy to term.*

Treasury, Transportation, Housing and Urban Development, and Judiciary

Federal Employees

The Treasury, Transportation, Housing and Urban Development, and Judiciary appropriations bill provides funding for the Federal Employees Health Benefits Program (FEHBP), the network of insurance plans that covers nearly eight million federal employees, their dependents, and retirees,²⁵ of whom 45 percent are women.

From 1983 until 1993, Congress prohibited the FEHBP from covering abortion services except in cases where the woman's life was endangered. Through the efforts of the Clinton administration, pro-choice congressional leaders, and the pro-choice

community, this restriction was finally lifted in 1993. However, since 1995, anti-choice legislators have annually re-imposed this restriction by prohibiting FEHBP from covering abortion services except in cases of life endangerment, rape, or incest.

District of Columbia

Medicaid - Locally Raised Revenue

The Hyde amendment has restricted the use of federal Medicaid funds for abortion services for low-income women in the District of Columbia since 1977, just as it has for Medicaid-eligible women in the 50 states. But while all 50 states have the option of providing state funding for abortion services, the District's use of its own funds is dictated by Congress through the appropriations process. From 1988 until 1993, the District was prohibited from using its own, locally raised revenue to provide access to these services except in cases where the woman's life is endangered. Congress lifted this restriction in 1993 and permitted the District to use locally raised funds to pay for abortion services. However, the restriction on the use of locally raised revenue - except in cases of life endangerment or if the pregnancy is the result of rape or incest - has been re-imposed every year since 1995. Not only does this policy treat the citizens of the District differently than all other Americans, the D.C. ban also disproportionately affects communities of color. Of the 60,500 District residents whose access to abortion care is affected by the local-funds ban,²⁶ the vast majority—nearly 96 percent—are black or Latina.²⁷

Commerce, Justice, and Science

Correctional Facilities

From 1987 until 1993 and from 1995 to the present, the State, Commerce, Justice, and Science appropriations bill, which provides funding for the Federal Bureau of Prisons, prohibited the use of these funds to provide inmates at federal correctional institutions with abortion services except in cases where the woman's life was endangered or if the pregnancy was the result of rape. This ban was lifted in 1993. However, the ban has been reimposed every year since 1995. An estimated 13,841 women are currently incarcerated in facilities operated by the Federal Bureau of Prisons.²⁸

Further Attacks on Reproductive-Health Options: Title X Family-Planning Clinics

Title X of the Public Health Service Act makes grants available to both public and private medical facilities to provide family-planning services for low-income women. Title X is particularly important in providing family-planning services to low-income women who fail to qualify for Medicaid and do not have health insurance. For many women, Title X clinics provide the only basic health care that they receive. Almost 85 percent of Title X clients are from low-income households, and African-American women are overrepresented among the

clinic population.²⁹ A permanent ban was placed on the use of any Title X federal funds to provide abortion care when it was passed in 1970, before *Roe v. Wade* was decided.

Anti-choice legislators have attempted to restrict the ways in which Title X grantees may use funds they receive from non-federal government sources as well as federal funds. These restrictive attempts have included a prohibition on abortion counseling; a requirement that Title X clinics that use non-federal funds to provide abortion services notify a minor's parents of an abortion, with no bypass procedure, no exception for rape, and limited exceptions for incest; and a parental-notification requirement for minors seeking family-planning services.³⁰

Anti-choice administrations also have attempted to impose additional restrictions on Title X clinics. During the Reagan/Bush I era, the administrations tried to impose a gag-rule policy that would have prohibited service providers at Title X clinics from including information about abortion when they were counseling women about their options for dealing with an unintended pregnancy, even if women specifically asked for information about abortion procedures. Service providers also would have been prohibited from giving referrals to women seeking abortion services. The gag rule was opposed by a bipartisan majority in both the House and the Senate and was challenged in court. Although ultimately ruled constitutional by the Supreme Court,³¹ the gag rule never took effect.³² In January 1993, the gag rule was lifted by President Clinton in one of his first executive orders.³³

Conclusion

NARAL Pro-Choice America opposes discriminatory funding bans, which segregate abortion care — a vital component of women's reproductive health — from other health-care services. The bans described above bear most heavily upon low-income women. These bans undoubtedly force many women to bear children they are not prepared to raise, or to sacrifice funds vitally needed for other necessities in order to pay for abortion care. The personal and social costs of these bans are heavy and completely avoidable.

January 1, 2010

Notes, cont.

- ¹ Patricia Donovan, *The Politics of Blame: Family Planning, Abortion and the Poor*, THE GUTTMACHER INSTITUTE 36 (1995).
- ² NARAL PRO-CHOICE AMERICA & NARAL PRO-CHOICE AMERICA FOUNDATION, *The Reproductive Rights and Health of Women of Color* (2000), at 22.
- ³ Council on Scientific Affairs, American Medical Association, *Induced Termination of Pregnancy Before and After Roe v. Wade*, 268 JAMA 3231, 3238 (1992).
- ⁴ Rachel K. Jones et al., *Patterns in the Socioeconomic Characteristics of Women Obtaining Abortions in 2000-2001*, PERSP. ON SEXUAL & REPROD. HEALTH 34 (2002).
- ⁵ THE ALAN GUTTMACHER INSTITUTE, *Facts in Brief: Induced Abortion* (July 2008), at http://www.agi-usa.org/pubs/fb_induced_abortion.pdf (last visited Oct. 16, 2009)
- ⁶ Stanley K. Henshaw, *Factors Hindering Access to Abortion Services*, 27 FAM. PLAN. PERSP. 56, 57 (1995).
- ⁷ THE ALAN GUTTMACHER INSTITUTE & THE KAISER FAMILY FOUNDATION, *Issue Brief: An Update on Women's Health Policy, "Medicaid's Role in Family Planning,"* (Oct. 2007), at http://www.kff.org/womenshealth/upload/7064_03.pdf (last visited Oct. 16, 2009) .
- ⁸ NARAL PRO-CHOICE AMERICA FOUNDATION, *Who Decides? The Status of Women's Reproductive Rights in the United States* (19th ed. 2010), at www.prochoiceamerica.org/whodecides.
- ⁹ NARAL PRO-CHOICE AMERICA FOUNDATION, *Who Decides? The Status of Women's Reproductive Rights in the United States* (19th ed. 2010), at www.prochoiceamerica.org/whodecides.
- ¹⁰ NARAL PRO-CHOICE AMERICA FOUNDATION, *Who Decides? The Status of Women's Reproductive Rights in the United States* (19th ed. 2010), at www.prochoiceamerica.org/whodecides.
- ¹¹ KAISER FAMILY FOUNDATION (KFF), *Distribution of the Nonelderly with Medicaid by Race/Ethnicity, states (2007-2008), U.S. (2008)* at <http://www.statehealthfacts.org/comparebar.jsp?ind=158&cat=3> (last visited Oct. 16, 2009).
- ¹² See generally *Hyde- 30 Years is Enough!* at http://www.hyde30years.nnaf.org/add_participants.html (last visited Oct. 16, 2009).
- ¹³ 42 U.S.C. § 426-1 (2003) (WESTLAW through P.L. 108-144 (excluding P.L. 108-136, 108-137)).
- ¹⁴ 42 U.S.C. § 426(b) (2003) (WESTLAW through P.L. 108-144 (excluding P.L. 108-136, 108-137)).
- ¹⁵ *Harris v. McRae*, 448 U.S. 297, 339 (1980) (Marshall, J., dissenting).
- ¹⁶ F. Gary Cunningham, M.D. et al., *Williams Obstetrics* (20th ed. 1997), 693.
- ¹⁷ Rachel K. Jones et al., *Abortion in the United States: Incidence and Access to Services, 2005*, 40 PERSP. ON SEXUAL & REPROD. HEALTH 6, 11 Table 3 (2008).
- ¹⁸ INDIAN HEALTH SERVICE (IHS), *Indian Health Service: Fact Sheet* (Feb. 19, 2002), at <http://www.ihs.gov/AboutIHS/ThisFacts.asp> (last visited Oct. 16, 2009).

Notes, cont.

- ¹⁹ Kati Schindler et al., *Indigenous Women's Reproductive Rights: The Indian Health Service and Its Inconsistent Application of the Hyde Amendment*, at http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/indigenous_women.pdf (last visited Oct. 16, 2009).
- ²⁰ TRICARE Media Readiness Room; Resources; Number of Tricare Eligibles by State, at http://www.tricare.osd.mil/pressroom/press_state.aspx (last visited Oct. 16, 2009).
- ²¹ Presidents Memorandum on Abortions in Military Hospitals, 29 Weekly Comp. Pres. Doc. 88 (Jan. 22, 1993).
- ²² AGI, *Uneven & Unequal, Insurance Coverage and Reproductive Health Services* 19 (1994), 19.
- ²³ H.AMDT.805 to H.R.5122, 109th Cong., Roll Call Vote No. 136, (2006).
- ²⁴ Peace Corps, *Peace Corps Fast Facts*, (last modified Aug. 24, 2009), at <http://www.peacecorps.gov/index.cfm?shell=learn.whatiscpc.fastfacts> (last visited Oct. 16, 2009).
- ²⁵ U.S. Office of Personnel Management, *The Fact Book, Federal Civilian Workforce Statistics* (2007), 82, at <http://www.opm.gov/feddata/factbook/> (last visited Oct. 16, 2009).
- ²⁶ Kaiser Family Foundation (KFF), *District of Columbia: Distribution of the Nonelderly with Medicaid by Gender, states (2007-2008), U.S. (2008)*, at <http://www.statehealthfacts.org/profileind.jsp?ind=157&cat=3&rgn=10> (last visited Oct. 15, 2009).
- ²⁷ In the District nearly 84 percent of non-elderly Medicaid recipients are Black, and 11 percent are Latino. Additionally, almost 54 percent of residents receiving assistance are women. See KAISER FAMILY FOUNDATION (KFF), *District of Columbia: Distribution of the Nonelderly with Medicaid by Race/Ethnicity, states (2007-2008), U.S. (2008)*, at <http://www.statehealthfacts.org/profileind.jsp?ind=157&cat=3&rgn=10> (last visited Oct. 15, 2009); KFF, *District of Columbia: Distribution of the Nonelderly with Medicaid by Gender, states (2007-2008), U.S. (2008)*, at <http://www.statehealthfacts.org/profileind.jsp?ind=157&cat=3&rgn=10> (last visited Oct. 15, 2009).
- ²⁸ Federal Bureau of Prisons, *Quick Facts* (Rev. Sept. 26, 2009), at <http://www.bop.gov/news/quick.jsp#2> (last visited Oct. 16, 2009).
- ²⁹ NARAL PRO-CHOICE AMERICA & NARAL PRO-CHOICE AMERICA FOUNDATION, *The Reproductive Rights and Health of Women of Color* (2000), at 20.
- ³⁰ ALAN GUTTMACHER INSTITUTE (AGI), *Efforts Renew to Deny Family Planning Funds to Agencies that Offer Abortion* (Feb. 2002), at <http://www.guttmacher.org/pubs/tgr/05/1/gr050104.pdf> (last visited Oct. 16, 2009); NARAL PRO-CHOICE AMERICA & NARAL PRO-CHOICE AMERICA FOUNDATION, "Nationwide Trends," *Who Decides? The Status of Women's Reproductive Rights in the United States* (14th ed. 2005).
- ³¹ *Rust v. Sullivan*, 500 U.S. 173 (1991).
- ³² ALAN GUTTMACHER INSTITUTE (AGI), *Title X 'Gag Rule' Is Formally Repealed* (Aug. 2000), at <http://www.agi-usa.org/pubs/journals/gr030413.html> (last visited Oct. 16, 2009).
- ³³ President's Memorandum on the Title X Gag Rule, 29 Weekly Comp. Pres. Doc. 87 (Jan. 22, 1993); 42 C.F.R. § 59.1 et seq. (2001); see also 65 Fed Reg. 41270-41280 (2000).