Discriminatory Bans 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 abortion illegal, anti-choice legislators have tried to make the procedure nearly impossible for women to obtain by placing abortion services financially out of reach. Anti-choice lawmakers have used the appropriations process to restrict how public funds may be used, prohibiting federal funding of abortion care in most situations. The intent of these funding bans, which disproportionately impact women of limited means, is to render abortion services inaccessible to as many women as possible. Former anti-choice Rep. Henry Hyde (R-IL) explicitly declared this intention during debate on his amendment to deny abortion coverage to millions of low-income Medicaid recipients: "I certainly would like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available is the…Medicaid bill."[1] Since the late 1970s, anti-choice politicians have followed in Hyde's footsteps, enacting funding bans that impose significant, and in some cases insurmountable, obstacles to a woman's ability to exercise her constitutionally protected right to choose.

Singling out abortion services for exclusion from federal health-care plans that cover pregnancy-related care jeopardizes women's health and discriminates against low-income women and women in public service.

- Low-income women often have difficulty raising the money to pay for abortion care, and research indicates that economic barriers often cause them to obtain abortion care two to three weeks later in pregnancy than do wealthier women.[2] This is especially problematic because the cost of abortion increases the longer the pregnancy continues.

Later abortion care, which is already inaccessible to women in many states, ranges into the thousands of dollars, which can pose an insurmountable cost.[3] 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.[4]

- 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.[5]

- A study by the Guttmacher Institute shows that Medicaid-eligible women in states whose Medicaid programs exclude abortion coverage have abortion rates of about half of those of women in states that fund abortion care.[6] 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. Fifty-eight percent of women who chose abortion report that they would have liked to have accessed care earlier and nearly 60 percent of women who experienced delay in obtaining abortion services cited raising money or accessing a provider as primary reasons for postponing care.[7]

- Abortion care after the first trimester of pregnancy is more complicated and expensive, and there are far fewer providers who offer abortion services at that stage.[8] 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.[9] Absent restrictive language included in the appropriation bill, Medicaid pays for "medically necessary" services, including abortion care. Ten percent of U.S. adult women receive their health coverage through Medicaid, and in 2008, more than one in three low-income women of child-bearing age looked to Medicaid for health care.[10,11]

However, since 1980, 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.[12] 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.[13] 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, through which many women with children are insured.[14]

When Congress added exceptions for cases of rape and incest to the Hyde amendment's prohibition on federal Medicaid funding for abortion care, more than one-third of the states initially refused to comply with the federal law. Eleven states were ordered into compliance by federal courts.[15] 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.[16]

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.[17] In 13 of these states, courts have ruled that their state constitutions prohibit the exclusion of medically necessary abortion care from medical-assistance programs.[18] The remaining four states fund abortion services beyond the restrictions of the Hyde amendment voluntarily, either through legislation or executive-branch policy.

Today, 58 percent of Medicaid enrollees are people of color.[19] While the largest single demographic group of Medicaid recipients is white, people of color are overrepresented among Medicaid enrollees, given their proportion of the general population. That women of color are more likely to be poor and without other health insurance can be understood to reflect the economic legacy of racism and racist policies that influenced socioeconomic status. Recognizing the particular impact of the Hyde amendment on the reproductive rights of women of color, a number of organizations representing these communities continue to campaign on civil-rights grounds to lift the discriminatory ban on the use of public funds for abortion care.

Medicare - The Hyde Amendment

Title XVIII of the Social Security Act establishes the Medicare program.[20] 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,[21] and those who have received Social Security Disability Insurance for at least two years.[22]

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.[23] Unlike the joint state/federal Medicaid program, Medicare is funded solely by the federal government. Thus, Medicare beneficiaries in every state are denied access to publicly funded 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.[24] In addition, pregnancy can aggravate already existing disabilities such as hypertension, which, if not controlled, may cause convulsions and even death.[25]

Disabled women also face unique obstacles in obtaining access to abortion care. Some women receiving Medicare are too ill to hold a job, and thus may have extreme difficulty raising funds for abortion services. Moreover, 87 percent of U.S. counties lack an abortion provider,[26] and the burdens of traveling for care may be particularly difficult for Medicare beneficiaries. Difficulty finding a provider may be further exacerbated by the fact that some clinics and doctors' offices decline to serve persons with complicated health conditions, and, 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 2 million American Indians and Alaska Natives.[27] 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 IHS legislation prohibited these facilities from providing abortion services unless the woman's life was endangered, even if she paid for the procedure herself. Today, federal IHS policy requires the program to follow the federal Medicaid restrictions with regard to abortion funding.[28] 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 for most IHS beneficiaries because of the remote locations of most reservations and the lack of abortion facilities within the IHS system.[29] Funding restrictions on abortion coverage in the IHS, combined with other barriers to access, render the right to choose effectively meaningless for Native-American women who rely on IHS for their health care.

Defense

Servicewomen and Female Military Dependents

The Department of Defense (DoD) provides abortion services to women serving in the military and female military dependents as part of TRICARE, its health-insurance plan, only in three instances: life endangerment, rape, or incest.[30]

After the 1973 *Roe v. Wade* decision, the Department of Defense provided abortion services as part of its health-insurance plan. Abortion was not controversial until a vocal minority began electing anti-choice lawmakers. In 1978, Congress blocked the DoD health plan from covering abortion except in cases of life endangerment, rape, and incest.

Going even further, in 1981 Congress expanded the TRICARE coverage ban to exclude cases of sexual assault. In 2012 that restriction finally was lifted through the FY'13 National Defense Authorization Act.

(Unfortunately, another separate abortion ban remains in force: in all other cases, current law forbids servicewomen and female military dependents from using their *own private funds* for abortion services at military hospitals. Please see NARAL Pro-Choice America's fact sheet, *Lift the Ban on Privately Funded Abortion Services for Military Women Overseas* for more information on this ban.)

Department of Veterans Affairs

Veterans Health Administration

Since 1992, women who rely on the Veterans Health Administration for their health insurance have been barred from abortion coverage in all cases. The anti-choice provision was enacted in the Veterans' Health Care Act of 1992, which established a new set of certain health-care services for women veterans, including pap smears, breast examinations and mammography, and "general reproductive care." However, the language that laid out this new package of well-woman's services explicitly excluded coverage of abortion care, with no exceptions.[31]

Foreign Operations

Peace Corps Volunteers

The Peace Corps program is funded through the Foreign Operations appropriations bill. Of the 8,655 U.S. citizens who are currently volunteers and trainees for the Peace Corps, 62 percent are women.[32] The program provides health-care coverage to its volunteers and trainees, but since 1979, appropriations provisions have 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*.[33]

In 2011 and 2012, the Senate State, Foreign Operations, and Related Programs Appropriations bills have included language lifting the Peace Corp ban in cases of rape, incest, or when the life of the woman is in danger.[34] Unfortunately, neither year did the language make it into final budget legislation. Congress has not yet passed an FY'13 spending bill.

Financial Services and General Government

Federal Employees

The Financial Services and General Government 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, of whom 44 percent are women.[35]

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 lifted in 1993.[36] However, since 1995, anti-choice legislators have annually re-imposed this restriction and thereby prohibited FEHBP plans from covering abortion services except in cases of life endangerment, rape, or incest.[37]

District of Columbia - Medicaid

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. However, 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.[38] Congress lifted this restriction in 1993 and permitted the District to use locally raised funds to pay for abortion services.[39] However, the restriction was annually re-imposed from 1995 to 2009. In 2009, Congress lifted the ban, but during negotiations over the 2011 budget, anti-choice forces again prevailed in re-imposing the restriction.[40]

Following the reinstatement of the D.C. ban in April 2011, the city was forced abruptly to drop coverage for abortion services from its health programs. At least 28 D.C. Medicaid enrollees were scheduled to receive abortion care at a local clinic just days after the budget deal was struck.[41] These women who depended on the D.C. Medicaid program to meet their health needs suddenly were left on their own to scramble for funds. The D.C. ban is unjust not only because it treats citizens of the District differently than all other Americans, but also because the policy affects disproportionately

communities of color. Of the District residents whose access to abortion care is affected by the local-funds ban,[42] the vast majority—94 percent—are black or Latina.[43]

Commerce, Justice, and Science

Correctional Facilities

From 1995 to the present, the State, Commerce, Justice, and Science appropriations bill, which provides funding for the Federal Bureau of Prisons, has 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.[44] This prohibition was also in place from 1987 to 1993, and then briefly lifted in 1993. Regrettably, the ban was reinstated in 1995 and every year since. An estimated 14,228 women currently are incarcerated in facilities operated by the Federal Bureau of Prisons.[45]

Department of Homeland Security

Immigration-Detention Facilities

The House-passed FY'13 and FY'14 Homeland Security spending bills both included an amendment prohibiting U.S. Immigration and Customs Enforcement (ICE) from funding abortion services for women held in immigration detention facilities, except in cases of life endangerment, rape, or incest.[46] ICE already self-imposes this funding restriction,[47] but the amendment would have codified it in federal law. (As originally introduced in the FY'13 bill, the amendment would have limited exceptions only to cases of life endangerment and rape. Unable to block the proposal, pro-choice members succeeded in adding an incest exception.) The Senate's versions of the bills do not include this language, and Congress has not yet passed a FY'14 spending bill.

Conclusion

NARAL Pro-Choice America opposes discriminatory funding bans, which segregate abortion care—an essential component of women's reproductive health—from other health-care services. The bans described above bear most heavily upon low-income women, and 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, unacceptable, and completely avoidable.

January 1, 2014

Notes:

[1] Heather Boonstra, *The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States*, GUTTMACHER POL'Y REV. 10 (2007), *at* http://www.guttmacher.org/pubs/gpr/10/1/gpr100112.html (last visited Aug. 1, 2013).

[2] Center for Reproductive Rights, *Women's Reproductive Rights in the United States: A Shadow Report* (June 2006).

[3] Rachel K. Jones et al., *Abortion in the United States: Incidence and Access to Services,* 40 PERSP. ON SEXUAL AND REPROD. HEALTH 6, 14 (2008).

[4] NARAL Pro-Choice America & NARAL Pro-Choice America Foundation, *The Reproductive Rights and Health of Women of Color* (2000), at 22.

[5] Council on Scientific Affairs, American Medical Association, *Induced Termination of Pregnancy Before and After Roe v. Wade*, 268 JAMA 3231, 3238 (1992).

[6] Rachel K. Jones et al., *Patterns in the Socioeconomic Characteristics of Women Obtaining Abortions in 2000-2001*, PERSP. ON SEXUAL & REPROD. HEALTH 34 (2002).

[7] Guttmacher Institute, *Facts in Brief: Facts on Induced Abortion in the United States* (July 2013), *at* http://www.guttmacher.org/pubs/fb_induced_abortion.html (last visited Aug. 1, 2013).

[8] Guttmacher Institute, *Facts in Brief: Facts on Induced Abortion in the United States* (July 2013), *at* http://www.guttmacher.org/pubs/fb_induced_abortion.html (last visited Aug. 1, 2013).

[9] 42 U.S.C. §§ 1396-1396v.

[10] Kaiser Family Foundation, *Women's Health Care Chartbook: Key Findings from the Kaiser's Women's Health* Survey (May 2011), *at* http://www.kff.org/womenshealth/upload/8164.pdf (last visited Aug. 1, 2013).

[11] Kaiser Family Foundation, *Women's Health Care Chartbook: Key Findings from the Kaiser's Women's Health* Survey (May 2011), *at* http://www.kff.org/womenshealth/upload/8164.pdf (last visited Aug. 1, 2013).

[12] P.L. 94-439, 94th Cong. (1976). Congress enacted the Hyde amendment, which restricts federal funding for abortion, in 1976, but the policy was litigated and did not go into effect until 1980.

[13] P.L. 103-112, 103rd Cong. (1993).

[14] P.L. 105-33, 105th Cong. (1997).

[15] Guttmacher Institute, *Rights Without Access: Revisiting Public Funding of Abortion for Poor Women*, 3 GUTTMACHER REP. ON PUB. POL'Y (April 2000) a*vailable at* http://www.guttmacher.org/pubs/tgr/03/2/gr030208.html (last visited Aug. 1, 2013).

[16] NARAL Pro-Choice America &NARAL Pro-Choice America Foundation, *Who Decides? The Status of Women's Reproductive Rights in the United States* (22nd ed. 2013), *available at* http://www.WhoDecides.org (last visited Aug. 1, 2013). Notably, in 2011, anti-choice lawmakers in Iowa also attempted to remove federally required exceptions for cases of rape and incest from the state's Medicaid policy through an amendment to a FY'11 spending bill. After a protracted fight that threatened to shut down the state government, the amendment ultimately was not included in the final budget compromise, and Iowa's existing Medicaid policy largely was left intact. William Petroski, *Update: Iowa Legislature adjourns; dispute on abortion rules resolved,* DES MOINES REGISTER, June 30, 2011, *available at* http://blogs.desmoinesregister.com/dmr/index.php/2011/06/30/update-agreement-reached-on-abortion-iowa-legislature-set-to-adjourn/ (last visited Aug. 1, 2013). In 2012, unfazed, 41 lawmakers petitioned

Notes, cont.

the Iowa Department of Human Services to eliminate abortion funding in all cases other than life endangerment, but the governor's administration denied the request. Laura Bassett, *Iowa GOP Targets Abortions for Low-Income Rape, Incest Victims*, HUFFINGTON POST, June 20, 2012, *at* http://www.huffingtonpost.com/2012/06/20/iowa-gop-abortion-rape-incest_n_1613336.html (last visited Aug. 1, 2013).

[17] NARAL Pro-Choice America & NARAL Pro-Choice America Foundation, *Who Decides? The Status of Women's Reproductive Rights in the United States* (22nd ed. 2013), *available at* http://www.WhoDecides.org (last visited Aug. 1, 2013).

[18] Guttmacher Institute, *State Policies in Brief*, "State Funding of Abortion Under Medicaid" (Oct. 2011).

[19] Kaiser Family Foundation (KFF), *Distribution of the Nonelderly with Medicaid by Race/Ethnicity, states (2010-2011), U.S. (2011)* http://www.statehealthfacts.org/comparebar.jsp?ind=158&cat=3 (last visited Oct. 17, 2012).

[20] 42 U.S.C. §§ 1395-1395ccc.

[21] 42 U.S.C. § 426-1 (2003) (WESTLAW through P.L. 108-144 (excluding P.L. 108-136, 108-137)).

[22] 42 U.S.C. § 426(b) (2003) (WESTLAW through P.L. 108-144 (excluding P.L. 108-136, 108-137)).

[23] P.L. 105–277, 105th Cong. (1998).

[24] *Harris v. McRae*, 448 U.S. 297, 339 (1980) (Marshall, J., dissenting).

[25] F. Gary Cunningham, M.D. et al., *Williams Obstetrics* (20th ed. 1997), 693.

[26] 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).

[27] Indian Health Service (IHS), *Indian Health Disparities* (January 2013), *available at* http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/factsheets/Disparities_2013.pdf (last visited Aug. 1, 2013).

[28] 25 U.S.C. § 1676.

[29] 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 Aug. 1, 2013).

[30] 10 U.S.C. § 1093.

[31] 106 STAT. 4943, 4947 (1992); Sidath Viranga Panagala & Erin Bagalman, *Health Care for Veterans: Answers to Frequently Asked Questions,* Aug. 1, 2013, at 7, *available at* https://www.fas.org/sgp/crs/misc/R42747.pdf.

[32] Peace Corps, *Peace Corps Fast Facts*, (last modified Sept. 2012), *available at* http://www.peacecorps.gov/index.cfm?shell=learn.whatispc.fastfacts (last visited Aug. 1, 2013).

[33] P.L. 111-117, 111th Cong. (2009).

[34] S.1601, 112th Cong. (2011); S.3241 112th Cong. (2012). Current law does not allow federal funds to pay for abortion care for Peace Corps volunteers and trainings in any circumstance, even when a woman's

Notes, cont.

life is in danger. Adding exceptions for rape, incest, and life endangerment would align Peace Corps health policy with the Hyde amendment and other federal laws concerning women who obtain their health care through the federal government.

[35] U.S. Office of Personnel Management, *The Fact Book, Federal Civilian Workforce Statistics* (2007), 82, *available at* http://www.opm.gov/feddata/factbook/ (last visited Aug. 1, 2013).

[36] Adam Clymer, *Federal Employees Given Coverage for Abortions*, N.Y. TIMES, Aug. 4, 1993.

[37] P.L. 111-117, 111th Cong. (2009).

[38] Dornan Amdt.286 (1987); H.R. 2713, 100th Cong. (1987).

[39] P. L. 103-127, 107 Stat 1336 (1993); P. L. No. 103-334, 108 Stat 2576 (1994).

[40] P.L. 112-10, 112th Cong. (2011).

[41] Aaron Morrissey, *D.C. Abortion Funding Ban Begins To Rear Its Ugly Head* (Apr. 14, 2011) *available at* http://dcist.com/2011/04/abortion_funding_cut.php (last visited Aug. 1, 2013).

[42] Kaiser Family Foundation (KFF), *District of Columbia: Distribution of the Nonelderly with Medicaid by Gender, states (2010-2011), U.S. (2011), available at* http://www.statehealthfacts.org/profileind.jsp?cat=3&sub=42&rgn=10 (last visited Aug. 1, 2013).

[43] In the District 79 percent of non-elderly Medicaid recipients are Black, and 15 percent are Latino. Additionally, approximately 55 percent of residents receiving assistance are women. *See* KFF, *District of Columbia: Distribution of the Nonelderly with Medicaid by Race/Ethnicity, states (2010-2011), U.S. (2011), at* http://www.statehealthfacts.org/profileind.jsp?cat=3&sub=42&rgn=10 (last visited Aug. 1, 2013); KFF, *District of Columbia: Distribution of the Nonelderly with Medicaid by Gender, states (2010-2011), U.S. (2011), available at* http://www.statehealthfacts.org/profileind.jsp?cat=3&sub=42&rgn=10 (last visited Aug. 1, 2013).

[44] P.L. 111-117, 111th Cong. (2009).

[45] Federal Bureau of Prisons, *Quick Facts* (Rev. Sept. 2012), *available at* http://www.bop.gov/news/quick.jsp#2 (last visited Aug. 1, 2013).

[46] H.R.5855, 112th Cong. (2012).

[47] Department of Homeland Security, U.S. Immigration and Customs Enforcement *2011 Operations Manual ICE Performance-Based National Detention Standards*, *available at http://www.ice.gov/detention-standards/2011/* (last visisted Aug. 1, 2013).