PUBLIC FUNDING FOR ABORTION: MEDICAID AND THE HYDE AMENDMENT

About Medicaid

Authorized in 1965, Medicaid is a joint federal-state program that provides the nation's low-income population with basic health and long-term care coverage. Medicaid is the largest health care program in the United States, and covers more than 50 million people.[i] Under Medicaid states receive federal matching funds to provide health care for low-income individuals.

Medicaid coverage is critical to the health care of millions of women. More than 16 million women receive their basic health and long-term coverage through Medicaid.[ii] In 2003, Medicaid covered one in ten women and one in five low-income women.[iii] In 2003, 11.5% of women of reproductive age were covered by Medicaid.[iv]

Currently, all state Medicaid programs must cover pregnant women who meet the federal income requirements. Many states have elected to cover women with incomes that are higher than the federal requirements. However, this coverage is not without limits, and abortion services are among the provisions that are most stringently regulated.

Medicaid Spending

Medicaid is the largest form of aid to the states from the federal government, comprising 43% of all federal grants.[v] As the national economy has worsened, state tax revenue has lessened and health care costs have continued to rise. This resulted in more people eligible for Medicaid.[vi] This has placed pressure on states to control Medicaid costs, typically the second-largest budget expenditure.[vii] The federal government is also looking at scaling back Medicaid funding, and the Bush administration has proposed to reduce Medicaid spending by $35 billion over the next ten years. These cuts will especially impact women.

The Hyde Amendment

After *Roe v. Wade* decriminalized abortion in 1973, Medicaid covered abortion care without restriction. In 1976, Representative Henry Hyde (R-IL) introduced an amendment that later passed to limit federal funding for abortion care. Effective in 1977, this provision, known as the Hyde Amendment, specifies what abortion services are covered under Medicaid.

Over the past two decades, Congress has debated the limited circumstances under which federal funding for abortion should be allowed. For a brief period of time, coverage included cases of rape, incest, life endangerment, and physical health damage to the woman. However, beginning in 1979, the physical health exception was excluded, and in 1981 rape and incest exceptions were also excluded.

In September 1993, Congress rewrote the provision to include Medicaid funding for abortions in cases where the pregnancy resulted from rape or incest. The present version of the Hyde Amendment requires coverage of abortion in cases of rape, incest, and life endangerment.

Challenges to Hyde

The first challenges to the Hyde Amendment came shortly after its implementation. The Supreme Court has held that the Hyde Amendment restrictions are constitutional[viii] and that states participating in Medicaid are only required to cover abortion services for which they receive federal funding rather than all medically necessary abortions.[ix] Challenges under state constitutions have been more successful. Several lawsuits have been brought in individual states arguing that state constitutions afford greater protection for privacy and equal protection than the federal Constitution.[x]

Implementation of the Hyde Amendment

The Hyde Amendment affects only federal spending. States are free to use their own funds to cover additional abortion services. For example, Hawaii, New York, and Washington have enacted laws funding abortions for health reasons. Other states, such as Maryland, cover abortions for women whose pregnancies are affected by fetal abnormalities or present serious health risks. These expansions are important steps toward ensuring equal access to health care for all women.

Prior to the 1993 expansion of the Hyde Amendment, thirty states chose not to use their own Medicaid funds to cover abortions for pregnancies resulting from rape or incest.[xi] Initially, a number of states expressed resistance to comply with the expanded Hyde Amendment, and presently thirteen states are under court orders to comply and cover rape and incest in addition to life endangerment.[xii] Every court that has considered the Hyde Amendment's application to a state's Medicaid

program since 1993 has held that states continuing to participate in the Medicaid program must cover abortions resulting from rape or incest in order to be compliant with the Hyde Amendment, regardless of state laws that may be more restrictive.

STATE FUNDING FOR ABORTION UNDER MEDICAID

Funding under Hyde Amendment Only: Alabama, Arkansas, Colorado, Delaware, District of Columbia, Florida, Georgia, Idaho, Kansas, Kentucky, Louisiana, Maine, Michigan, Missouri, Nebraska, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, and Wyoming.

Hyde Amendment and Additional Health Circumstances: Indiana (physical health), Iowa (fetal abnormality), Mississippi (fetal abnormality), Utah (physical health and fetal abnormality), Virginia (fetal abnormality), and Wisconsin (physical health).

All or Most Health Circumstances: Alaska, Arizona, California, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, New York, Oregon, Vermont, Washington, and West Virginia.

Noncompliant with the Hyde Amendment: South Dakota (life endangerment only).

Impact of the Hyde Amendment

Unique barriers face low-income women accessing comprehensive reproductive health care. Barriers to abortion access such as the lack of providers, state laws delaying women from receiving timely care, and funding restrictions like the Hyde Amendment fall disproportionately on low-income women who have limited resources with which to overcome these obstacles. The Guttmacher Institute has found that 20-35% of Medicaid-eligible women who would choose abortion carry their pregnancies to term when public funds are not available.[xiii] Additionally, lack of public funding results in women waiting while they raise funds, postponing their abortions until later in their pregnancies when the costs and health risks can be higher. For women who are struggling to make ends meet and who do not have insurance that covers abortion care, the legal right to have an abortion does not guarantee access.

The restrictions imposed by the Hyde Amendment unfairly jeopardize the health and well-being of low-income women and their families. Women who do not have the ability to pay for abortion services may resort to self-inducing an abortion or obtaining unsafe, illegal abortions from untrained practitioners. Also, the Hyde Amendment harms women's health by denying coverage for abortion services in cases where women have serious physical or mental health concerns.

Conclusion

The Hyde Amendment marginalizes and stigmatizes abortion care rather than recognizing it as an essential component of women's health, and denies low-income women basic reproductive health care. The Hyde Amendment is reauthorized each year under appropriations bills for the Department of Labor and the Department of Health and Human Services. The current restrictive version of the Hyde Amendment does not provide coverage for abortions in cases of fetal abnormalities, or health exceptions apart from life-threatening conditions. Removing funding restrictions for abortion care is an integral step in ensuring that abortion remains safe, legal, and accessible. American women have had the legal right to choose abortion for more than thirty years. To achieve reproductive equality for all women, restrictive barriers such as the Hyde Amendment must be removed.

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[i] The Henry J. Kaiser Family Foundation, "The Medicaid Program at a Glance," Key Facts (January 2005) (available at http://www.kff.org/medicaid/upload/The-Medicaid-Program-at-a-Glance-Fact-Sheet.pdf).

[ii] The Henry J. Kaiser Foundation, "Medicaid's Role for Women," Issue Briefs: An Update on Women's Health Policy (November 2004) (available at http://www.kff.org/womenshealth/upload/Medicaid-s-Role-for-Women.pdf).

[iii] Id.

[iv] The Henry J. Kaiser Family Foundation and the Alan Guttmacher Institute, "Medicaid: A Critical Source of Support for Family Planning in the United States," Issue Briefs: An Update on Women's Health Policy (April 2005) (available at http://www.kff.org/womenshealth/upload/Medicaid-A-Critical-Source-of-Support-for-Family-Planning-in-the-United-States-Issue-Brief-UPDATE.pdf).

[v] The Henry J. Kaiser Family Foundation, "State Fiscal Conditions and Medicaid," Medicaid Facts (November 2005) (available at http://www.kff.org/medicaid/upload/4087-04.pdf).

[vi] Id.

[vii] Id.

[viii] See *Beal v. Doe*, 432 U.S. 438 (1977) and *Maher v. Roe*, 423 U.S. 464 (1977)

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

[x] Advocates bringing lawsuits have ensured state Medicaid coverage for abortions in all or most circumstances in Alaska, Arizona, California, Connecticut, Illinois, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, Oregon, Vermont, and West Virginia. Courts in Florida, Idaho, Kentucky, Michigan, North Carolina, Pennsylvania, and Texas have upheld funding restrictions under their respective state constitutions. Center for Reproductive Rights, "Portrait of Injustice: Abortion Coverage Under the Medicaid Program" (available at http://www.reproductiverights.org/pub_fac_portrait.html).

[xi] Bruce Alpert, "Fight Brews as Clinton Backs Medicaid Abortions," *New Orleans Times-Picayune*, December 30, 1993, at B1.

[xii] The Guttmacher Institute, "State Funding of Abortion Under Medicaid," State Policies in Brief (June 1, 2005) (available at http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf).

[xiii] Heather Boonstra and Adam Sonfield, "Rights Without Access: Revisiting Public Funding of Abortion for Poor Women," *The Guttmacher Report on Public Policy* vol.3(2) (April 2000) (available at http://www.guttmacher.org/pubs/tgr/03/2/gr030208.html).

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