Fatima Goss Graves
President and CEO
National Women's Law Center

House Appropriations Subcommittee on the
Departments of Labor, Health and Human Services, Education, and Related Agencies

"The Impact on Women Seeking an Abortion but are Denied Because of an Inability to Pay"

December 8, 2020

Dear Chairwoman DeLauro, Ranking Member Cole, and Members of the Subcommittee,

The National Women's Law Center fights for gender justice – in the courts, in public policy, and in our society – working across the issues that are central to the lives of women and girls, including child care and early learning, education, reproductive rights and health, income security, workplace justice, and addressing sexual harassment or assault.

Access to reproductive health care – including abortion – is vital to gender justice. The ability to make decisions about whether to have an abortion, and the ability to access abortion, is a key part of a person's liberty, equality, and economic security. As the U.S. Supreme Court affirmed in its 1992 *Planned Parenthood of Southeastern Pennsylvania v. Casey* decision: "The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."[i]

Yet despite this truth – or because of it – lawmakers continue to pass restrictions on a person's ability to make this fundamental decision. One of the most pernicious restrictions lawmakers have passed over the years is the Hyde Amendment. This restriction, a rider that Congress has attached to the annual appropriations bill since 1977, denies abortion coverage to individuals enrolled in the federal Medicaid program. Medicaid covers 25 million adult women in the U.S.,

two-thirds of whom are in their reproductive years (19 to 49), meaning that millions of individuals enrolled in Medicaid must pay out-of-pocket for abortion care except in very narrow circumstances.[ii] Over the years, Congress has extended the harmful reach of the Hyde Amendment to apply to many federal programs that provide health care including those serving in the U.S. military and Peace Corps, residents of the District of Columbia, veterans, federal employees, individuals in federal prisons and those detained in federal immigration facilities, individuals covered by the Indian Health Service, and young people who rely on the State Children's Health Insurance Program.

Although legislators opposed to reproductive health, rights, and justice have waged a decades-long systemic attack on the constitutional right to abortion, they have thus far been unsuccessful in overturning the right and polling shows that the majority of people in the U.S. do not want it to be overturned.[iii] And yet, many still are denied access to abortion – making it a right in name only – because of restrictions like the Hyde Amendment. Representative Henry Hyde, the amendment's original proponent and namesake, made clear that this was the exact goal of his amendment: to use the federal government's role in providing health coverage as a way to deny people access to abortion: "I would certainly 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."[iv] For too long and for too many women in this country, the Hyde Amendment has furthered that goal.

The Hyde Amendment is pernicious precisely because it targets the very people who struggle to make ends meet, disproportionately impacting Black and Hispanic women, single parents, and women who have not completed a high school education.[v] In 2014, nearly half of abortion

patients were women with family incomes below the Federal Poverty Level (FPL); women whose families earned less than 200% of the FPL made up an additional quarter of abortion patients,[vi] and women at this income level were more likely to be enrolled in Medicaid.[vii] The cost of abortion care can consume the monthly budget of a person with low income; even before the COVID-19 pandemic, nearly four in ten (37%) adults in the U.S. would have difficulty paying an unexpected $400 expense.[viii] This means that a person struggling to make ends meet would have to forego paying for basic necessities in order to pay for the procedure,[ix] a situation that is simply untenable for many. Indeed, studies show that when legislators restrict Medicaid coverage of abortion, it forces one in four lower-income women seeking an abortion to carry an unwanted pregnancy to term.[x] Moreover, the Hyde Amendment cruelly compounds existing barriers to health care, including maternal and other reproductive health care, particularly harming Black and Indigenous women,[xi] those who live in rural areas, and LGBTQ individuals.[xii]

Being denied an abortion can further deepen an individual's economic insecurity and has long-lasting and harmful effects on a person's well-being, job security, and workforce participation. Compared to women who received an abortion, women denied an abortion were more likely to have household incomes below the FPL, more likely to be in a position where they will need support from external sources, including the government, and more likely to be without a full-time job six months later.[xiii] Women who were denied abortions, compared to women who are able to have an abortion, are more likely to owe debt and be forced to incur negative "public records" (such as bankruptcy or eviction) on their credit reports after giving birth.[xiv] They are also more likely to be tethered to an abuser and to be at risk for continued violence, even if they end the romantic relationship.[xv]

Some Medicaid enrollees are able to overcome the coverage denial imposed by the Hyde Amendment to obtain an abortion. But the Hyde Amendment's harmful impact still reaches them. Some people who are denied coverage of abortion will be forced to postpone an abortion – inherently time-sensitive medical care – while attempting to find the necessary funds. In one study, more than one-third of women who had an abortion in the second trimester would have preferred to have the procedure earlier but could not because they needed to raise the necessary funds.[xvi] Without insurance coverage, individuals are caught in a vicious cycle of raising money while abortion care costs increase.

It is important to note that prohibitions on insurance coverage of abortion do not exist in a vacuum. Denials of abortion coverage operate alongside a range of other medically unnecessary barriers erected by lawmakers who want to prevent individuals from making the decision that is best for them. In the last decade, state lawmakers have passed more than 450 restrictions on abortion access meant to shutter clinics and shame women from seeking an abortion.[xvii] These restrictions have resulted in fewer abortion providers and increased travel times and distances for individuals seeking care. Even if a person is ultimately able to reach a clinic, they are likely to face significantly longer wait times and increased costs, including the costs of travel, lodging, child care, and more expensive procedures. The many state restrictions – including those that require multiple trips or additional unnecessary procedures – also add to out-of-pocket costs. These costs all add up, making it harder for a person to access abortion care, especially when the Hyde Amendment denies them coverage for the medical care they need.

People who have made the decision to seek abortion care – but who are delayed, blocked, shamed, or judged by politicians who impose unnecessary restrictions and barriers – need greater access to the care they are seeking, not less. These restrictions do nothing to make abortion – an

already extremely safe procedure – safer. We urge Congress to focus its attention on lifting barriers and restrictions and ensuring that those who are deciding if and when to have a child are supported – not deliberately undermined – by our federal programs.

This is more true now. It is no accident that the historic reckoning on racial injustice comes amid a pandemic and economic crisis that has taken the lives and livelihoods of millions, who are disproportionately Black, Indigenous, and people of color. These crises have exposed deep-seated inequities and structural racism across our institutions and in our government. But the crises also give us an opportunity for change and to address longstanding harmful policies rooted in injustice. We urge Congress to take that opportunity now, by recognizing that the Hyde Amendment is one in a web of racist, sexist, and classist abortion restrictions.

The first step is for Congress to break the tradition of adding the Hyde Amendment to its annual appropriations bills and instead swiftly act to pass the Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act that would lift bans that restrict coverage of abortion. While the repeal of the Hyde Amendment will not reverse all of the barriers to abortion access that have been imposed on people seeking an abortion, eliminating it is a key piece to supporting people who need abortion care.

It is also a key piece of responding to the COVID-19 pandemic and related economic insecurity. At a time when people are struggling in so many ways and many are wanting to delay or prevent pregnancy,[xviii] policymakers must ensure that protecting access to reproductive health care is part of any effort to comprehensively address economic and health insecurity inflicted by both the pandemic and recession.

In taking the important step of eliminating the Hyde Amendment, Congress will be recognizing that access to reproductive health care, including abortion, is part of economic justice, racial justice, and any effort to ensure the success and well-being of every community. We call on Congress to put an end to the Hyde Amendment in the next annual appropriations bill so that no one is denied abortion coverage because of how much money they have or how they get their health insurance.

Thank you.

---

[i] *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 835 (1992).

[ii] Kaiser Family Foundation, Medicaid's Role for Women (2019), available at https://www.kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/.

[iii] Sixty-nine percent of Americans say *Roe v. Wade* should not be completely overturned and this share of Americans with this view has increased over recent years. *See* Hannah Fingerhut, *About seven-in-ten Americans oppose overturning Roe v. Wade*, PEW RESEARCH CENTER (January 3, 2017), https://www.pewresearch.org/fact-tank/2017/01/03/about-seven-in-ten-americans-oppose-overturning-roe-v-wade/.

[iv] 123 CONG. REC. 19,700 (1977) (statement of Rep. Henry Hyde).

[v] Kaiser Family Foundation, Medicaid's Role for Women (2019), available at https://www.kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/.

[vi] Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States*, 2008–2014, 107 AM. J. PUB. HEALTH 1904, 1906 (2017).

[vii] Kaiser Family Foundation, Medicaid's Role for Women (2019), available at https://www.kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/.

[viii] BD. GOVERNORS FED. RESERVE SYS., REPORT ON THE ECONOMIC WELL-BEING OF U.S. HOUSEHOLDS IN 2019, FEATURING SUPPLEMENTAL DATA FROM APRIL 2020, at 22 (May 2020), https://www.federalreserve.gov/publications/files/2019-report-economic-well-being-us-households-202005.pdf.

[ix] One study found that one-third of women getting an abortion had to delay or forgo paying bills, food, and even rent. One-half relied on financial assistance from others, but such assistance is never assured. *See* Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 AM. J. PUB. HEALTH 1904, 1906 (2017). *See also* M Antonia Biggs et al., *Understanding Why Women Seek Abortions in the US*, BMC WOMEN'S HEALTH, July 2013, at 6, and Rachel K. Jones et al., *At What Cost? Payment for Abortion Care by U.S. Women*, 23 WOMEN'S HEALTH ISSUES e173, e176 (2013).

[x] Stanley K. Henshaw et al, *Restrictions on Medicaid Funding for Abortions: A Literature Review,* GUTTMACHER INSTITUTE (July 2009), *https://www.guttmacher.org/report/restrictions-medicaid-funding-abortions-literature-review*.

[xi] Nat'l P'ship for Women & Families, Black Women's Maternal Health (2018), available at http://www.nationalpartnership.org/our-work/resources/health-care/maternity/black-womens-maternal-health-issue-brief.pdf; Roni Caryn Rabin, *Huge Racial Disparities Found in Deaths Linked to Pregnancy*, NEW YORK TIMES (May 7, 2019), https://www.nytimes.com/2019/05/07/health/pregnancy-deaths-.html.

[xii] AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE OPINION: HEALTH DISPARITIES IN RURAL WOMEN (2014), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co586.pdf?dmc=1&ts=20191112T0114132450; BIXBY CTR. FOR GLOB. REPRODUCTIVE HEALTH, *LGBTQ Patients Face Discrimination and Erasure When Seeking Reproductive Health Care*, https://bixbycenter.ucsf.edu/news/lgbtq-patients-face-discrimination-and-erasure-when-seeking-reproductive-health-care (last visited on Nov. 11, 2019).

[xiii] Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 AMERICAN JOURNAL OF PUBLIC HEALTH 407, 412-413 (2018).

[xiv] Sarah Miller, Laura R. Wherry, & Diana Greene Foster, *The Economic Consequences of Being Denied an Abortion*, NATIONAL BUREAU OF ECONOMIC RESEARCH WORKING PAPER NO. 26662 (2020).

[xv] Women in abusive relationships who sought and obtained abortion care experienced a decrease in physical violence from the man involved in the pregnancy; women who sought but were denied care were not so fortunate. Pregnant women in abusive relationships are also at risk of being killed by their abusers. Sarah CM Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, BMC MED., Sept. 2014, at 5; *see also id.* (women denied abortion were more likely to have sustained contact with the man involved in pregnancy); Deborah Tuerkheimer, *Conceptualizing Violence Against Pregnant Women*, 81 IND. L.J. 667, 672 (2006).

[xvi] Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 Contraception 334, 335 (2006).

[xvii] Elizabeth Nash, *Unprecedented Wave of Abortion Bans is an Urgent Call to Action*, GUTTMACHER INSTITUTE (May 22, 2019), https://www.guttmacher.org/article/2019/05/unprecedented-wave-abortion-bans-urgent-call-action.

[xviii] Laura D. Lindberg, *Early Impacts of the COVID-19 Pandemic: Findings from the 2020 Guttmacher Survey of Reproductive Health Experiences*, GUTTMACHER INSTITUTE 4–5 (June 2020), https://www.guttmacher.org/sites/default/files/report_pdf/early-impacts-covid-19-pandemic-findings-2020-guttmacher-survey-reproductive-health.pdf.