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The Heart of the Matter: Public Funding Of Abortion for Poor Women in the United States

By Heather D. Boonstra

This year marks the 34th anniversary of *Roe v. Wade,* the landmark U.S. Supreme Court decision that provided constitutional protection for abortion. In its 7-2 ruling, the Supreme Court recognized a woman's constitutional right to decide, in consultation with her physician, whether to terminate a pregnancy. This year also marks the 30th anniversary of the implementation of the Hyde Amendment, which bans federal funding for abortion in all but the most extreme circumstances. Named after longtime Rep. Henry Hyde (R-IL), who retired in 2006, the measure primarily affects Medicaid, the joint federal-state program that finances the provision of health services to eligible Americans deemed too poor to afford care on their own. More than seven million women of reproductive age—12% of all U.S. women in that age-group—are enrolled in the Medicaid program.

Medicaid enrollees are the poorest of poor Americans. For a woman to qualify, she must have an income below the very low eligibility ceiling set by her state. State income eligibility ceilings range as low as 18% of the federal poverty level in Arkansas and average 65% of poverty. That average translates to an annual income of $11,160, or roughly $930 per month for a family of three. Nearly four in 10 poor women of reproductive age are covered under Medicaid (related article, page 24). Most of these women are either pregnant or already a parent, as childless adults are typically ineligible at any income. As the average cost of an abortion at 10 weeks' gestation is $370, a poor woman with children who decides to have an abortion is likely to have very little left to survive on that month.

Poor women have been pawns in the congressional debate over abortion since the procedure became legal nationwide. For opponents of abortion, public funding has been a proxy for overturning *Roe.* As Hyde told his colleagues during a congressional debate over Medicaid funding in 1977, "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." For prochoice leaders, on the other hand, public funding was a matter of fundamental fairness and equal protection under the law. "If we now restrict or ban Medicaid funding for abortions, the government will accomplish for poor women indirectly what the 1973 [Supreme Court] opinion expressly forbade it to do directly…a right without access is no right at all," said then-Sen. Edward Brooke (R-MA), speaking in opposition to the Hyde Amendment during one of the early congressional debates.

Three Decades of Restrictions

It may be hard to believe today, but public funding of abortion was hotly debated and threatened to shut the government down more than once in the 1970s. Annual debates were intense and protracted, with dozens of votes and innumerable hours spent arguing over the respective merits or demerits of the words "serious" versus "severe," "permanent" versus "long-lasting," "forced rape" versus "rape." The first version of the Hyde Amendment passed under election-year pressure in 1976, only to be reopened the following year. In December 1977, after a months-long, paralyzing debate in Congress—during which the Senate sought to liberalize the Hyde

Amendment to cover all "medically necessary" abortions, while the House tried to prohibit public funding for abortion in any circumstance—a compromise was reached that permitted the federal government to pay its share of the cost of abortions for women enrolled in Medicaid only in cases where their lives were threatened, where two doctors certified that continuation of the pregnancy would result in "severe and long-lasting" physical health damage, or where rape or incest had been reported. Most observers at the time thought this compromise would stick, at least for the near future, but in 1979, the limited physical health exception was dropped, followed by the rape and incest exceptions in 1981.

In June 1980, the Supreme Court upheld the constitutionality of congressional restrictions on abortion funding in *Harris v. McRae*. The court ruled that the Hyde Amendment did not violate the due process and equal protection clauses of the Constitution, declaring that "a woman's freedom of choice [does not carry] with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices." The federal government could choose to encourage childbirth over abortion by paying for the former and not the latter—even if to do so might not be "wise social policy." According to the Court, because the government did not cause women to be poor, it is not obligated to level the playing field for poor women: "Although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation, and indigency falls within the latter category."

Following the Supreme Court ruling, and with Presidents Reagan and Bush in power during the 1980s, the Hyde Amendment essentially became a political nonissue. It was not until President Clinton took office in 1993 that poor women were on the agenda again. Prochoice forces in Congress fought hard to expand coverage to once again include cases of rape and incest, which they saw at the time as the first incremental step toward the long-term goal of an expanded Medicaid policy. That goal was dashed for the foreseeable future, however, when the Republicans, complete with a determined antiabortion leadership under Newt Gingrich (R-GA), gained control of the House in 1994.

The current version of the Hyde Amendment, established in 1997, allows federal funding for abortion in cases of rape and incest, as well as life endangerment, but tightens the life exception to permit payment only when the woman's life is threatened by "physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself." (At the state level, 17 states currently have a policy to use their own funds to pay for all or most medically necessary abortions sought by Medicaid recipients; see table.) In

CHOICE DENIED

Although some states use their own funds to pay for medically necessary abortions for poor women enrolled in Medicaid, most states follow the restrictive federal standard.

Funds Abortions in Cases of Life Endangerment, Rape or Incest	Funds All or Most Medically Necessary Abortions
Alabama	Alaska
Arkansas	Arizona
Colorado	California
Delaware	Connecticut
District of Columbia	Hawaii
Florida	Illinois
Georgia	Maryland
Idaho	Massachusetts
Indiana†	Minnesota
Iowa§	Montana
Kansas	New Jersey
Kentucky	New Mexico
Louisiana	New York
Maine	Oregon
Michigan	Vermont
Mississippi§	Washington
Missouri	West Virginia
Nebraska	
Nevada	
New Hampshire	
North Carolina	
North Dakota	
Ohio	
Oklahoma	
Pennsylvania	
Rhode Island	
South Carolina	
South Dakota*	
Tennessee	
Texas	
Utah†§	
Virginia§	
Wisconsin†	
Wyoming	
33 + DC	**17**

*Only covers abortions when necessary to protect the woman's life. †Covers those abortions necessary to avoid grave, long-lasting damage to the woman's physical health. §Covers abortions related to fetal abnormality.

addition, over the years, Congress has enacted legislation essentially banning abortion funding for other large groups of Americans dependent on the federal government for their health care or health insurance, ranging from federal employees and military personnel to women in federal prisons and low-income residents of the District of Columbia (see box).

The Impact

Researchers have studied the impact of funding restrictions on women's reproductive decisions and have found that despite the relatively high cost of the procedure, most poor women in need of an abortion manage to obtain one—a testament to women's determination not to bear a child they feel unprepared to care for. But their doing so often comes at a cost, as many poor women have to postpone their abortion. For those who are affected, the delay is substantial: Poor women take up to three weeks longer than other women to obtain an abortion. Little wonder that, according to a 2004 Guttmacher study published in *Contraception,* 67% of poor women having an abortion say they would have preferred to have had the abortion earlier.

Research indicates that women who are economi-

Additional Federal Restrictions on Abortion Funding

Over the past two decades, Congress has enacted bans similar to the Hyde Amendment (repeatedly as part of the annual appropriations process or within permanent law) that together affect millions of women who depend on the federal government for their health care.

Military Personnel and Their Dependents

• TRICARE (formerly the Civilian Health and Medical Program of the Uniformed Services) is the military health care system serving 6.9 million active duty military personnel, retired personnel and members of their families. Data on the number of female enrollees are unavailable, but TRICARE is open to 212,000 women of reproductive age currently serving in uniform and 1.6 million female veterans, more than 80% of whom are younger than 65.

• Since 1979, the Department of Defense has prohibited abortion funding for military personnel, retirees and their dependents through TRICARE except when a woman's life is in danger. In 1985, the ban was made permanent. In 1997, Congress went even further by prohibiting the performance of abortions in military hospitals overseas even if paid for privately, except in cases of rape, incest or where the woman's life would be at risk.

• For the half million men and women in uniform who are stationed overseas, the imposition of abortion restrictions is doubly unfair. The denial of abortion services is not only costly, but for many, military health facilities are the only source of safe, high-quality health care, particularly where abortion is illegal. Because they cannot obtain an abortion in a military hospital even if they paid for it themselves, the only options for many are to make expensive arrangements to obtain a medically safe abortion in another country or risk unsafe conditions in-country.

Federal Employees and Their Dependents

• The Federal Employees Health Benefits Program (FEHBP) is the largest employer-sponsored health insurance program in the nation, currently covering nine million federal employees and dependents. Over one million women are currently employed as part of the federal workforce, the vast majority of whom make less than $40,000 per year.

• In 1983, Congress imposed a ban on FEHBP funds from being used to pay for insurance plans that cover abortion, except where a woman's life is in jeopardy. After a brief two-year hiatus, a slightly less restrictive policy was reimposed in 1996. Currently, FEHBP funds cannot be used to pay for insurance coverage of abortion, except in cases of life endangerment, rape or incest.

American Indians and Alaskan Natives

• The Indian Health Service (IHS) comprises more than 142 clinics and health care facilities that provide medical care to 1.8 million American Indians and Alaskan Natives, 918,000 of whom are women. The median age of Native Americans within the

cally disadvantaged are delayed at two key stages. Poor women typically take more time than better-off women to confirm a suspected pregnancy, which could be because of the cost of a home pregnancy test or the difficulty in getting a test from a clinic or doctor. In addition, they take several more days between making the decision to have an abortion and actually obtaining one. When asked why they were delayed at this stage, poor women are about twice as likely as more affluent women (after controlling for other personal characteristics) to report having difficulties in arranging an abortion, usually because of the time needed to come up with the money.

Moreover, other research shows that poor women who are able to raise the money needed for an abortion often do so at great sacrifice to themselves and their families. Studies indicate that many such women are forced to divert money meant for rent, utility bills, food or clothing for themselves and their children.

One reason why delays in obtaining an abortion are important is because the cost and the risk of a procedure increases with gestational age. In 2001, the average charge for an abortion in 2001 was $370 at 10 weeks' gestation, but jumped to $650 at 14 weeks and $1,042 at 20 weeks. Thus,

United States is 29, a full seven years younger than for American citizens overall. Native Americans are less likely than other Americans to have health insurance and are twice as likely to have incomes below the poverty line. IHS-supported health care is the only source of care for most American Indians.

• Before 1996, the IHS only covered abortions in cases of life endangerment; since that time, its abortion policy has been brought into alignment with the Hyde Amendment to include exemptions for rape or incest as well.

Poor Women in the District of Colombia

• Some 27,000 women in the District of Colombia depend on Medicaid for their health care. To qualify for Medicaid, women who are working parents must have an income below 207% of the federal poverty level (roughly $35,540 for a family of three in 2007).

• Because Congress has ultimate authority over all District government spending and operations, Congress has been able to bar the District from using locally raised revenues for abortion, except in cases involving life, rape or incest, a policy which has been in place since 1989.

Women in Federal Prisons

• No group of women is more restricted in their health care choices than those in correctional facilities. There are more than 12,000 women serving time in federal prisons—a population that is increasing at the rate of 4.6% per year. Approximately 80% of women in U.S. correctional facilities are aged 18–44.

• Since 1987, the Department of Justice has been prohibited from paying for abortions for women in federal prisons, except in cases of life endangerment or rape. A female inmate who can afford to pay for an abortion may obtain one outside the prison using private funds; under these circumstances, she must be provided an escort at no cost. However, a "conscience" provision allowing workers in federal prisons to refuse to serve as an escort was added in 1989.

Peace Corps Volunteers

• The vast majority of the nation's nearly 8,000 Peace Corps volunteers serve in developing countries where safe and reliable health care is a rare luxury. Close to 5,000 are women, mostly unmarried and young (average age, 28 years). Peace Corps volunteers receive only modest monthly stipends meant to cover the cost of living and little more.

• Peace Corps volunteers are denied a federally subsidized abortion even when their lives are at risk. Since 1979, Congress has prohibited funding of abortions for any reasons. For many female Peace Corps volunteers experiencing an unintended pregnancy, a medically safe abortion may be many thousands of miles and dollars away.

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the longer it takes for poor women to obtain an abortion, the harder it is for them to afford it. In addition, the risk of complications increases exponentially at higher gestations, so many poor women become trapped in a vicious cycle in which their difficulties are exacerbated and their health risks increased.

Notably, a poor woman's access to a timely abortion depends on the policy in her state. According to the 2004 Guttmacher study, which looked at women obtaining abortion in 11 states, poor women living in states that use their own funds to pay for all or most medically necessary abortions obtain the procedure nearly a week earlier than women in the same states whose incomes are 100–149% of the poverty level, which are typically too high for Medicaid. By contrast, in states that restrict the use of funds for abortion, poor and near-poor women have their abortion at about the same gestation.

Perhaps the most tragic result of the funding restrictions, however, is that a significant number of women who would have had an abortion had it been paid for by Medicaid instead end up continuing their pregnancy. A number of studies have examined how many women are forced to forgo their right to abortion and bear children they did not intend. Studies published over the course of two decades looking at a number of states concluded that 18–35% of women who would have had an abortion continued their pregnancies after Medicaid funding was cut off. According to Stanley Henshaw, a Guttmacher Institute senior fellow and one of the nation's preeminent abortion researchers, the best such study, which was published in the *Journal of Health Economics* in 1999, examined abortion and birthrates in North Carolina, where the legislature created a special fund to pay for abortions for poor women. In several instances between 1978 and 1993, the fund was exhausted before the end of the fiscal year, so financial support was unavailable to women whose pregnancies occurred after that point. The researchers concluded that about one-third of women who would have had an abortion if support were available carried their pregnancies to term when the abortion fund was unavailable.

The Future

Most prochoice advocates would probably agree that today, just as in the late 1970s when annual battles raged in Congress for months at a time, the issue of Medicaid funding for poor women goes to the heart of who has access to abortion in this country and under what circumstances. Led by Speaker Nancy Pelosi (D-CA), the House leadership is now firmly supportive of abortion rights and access, even for poor women, and there is in all likelihood a prochoice majority, however slim, in the Senate. Yet the issue of public funding is not on the table, and it is not likely to be in the near-term future. Democratic majorities in the House and Senate are fragile, and party leaders, who have made it clear that they intend to govern "from the center," are unlikely to volunteer to take up such an inherently controversial issue anytime soon. Even many national prochoice leaders would argue that, with a president hostile to abortion rights and states like South Dakota passing abortion bans aimed at forcing an increasingly conservative Supreme Court to reconsider its fundamental abortion rulings, this is not the optimal time to force a reopening of the funding question.

Long stymied at the federal level, supporters of abortion funding have turned with some optimism to the states to jumpstart the movement. An impatient network of prochoice activists, spearheaded by the National Network of Abortion Funds, has teamed up to launch a public education campaign. The campaign, *Hyde—30 Years Is Enough!,* has been endorsed by the major national organizations and is thought to have a real chance of paying off in at least one state this year. Legislators in Maine are poised to debate whether that state should become the 18th in the nation to use its own funds to subsidize abortions for its Medicaid enrollees. It is to be hoped that Maine's campaign will be successful, and that it will be the first step in an accelerating, albeit undeniably uphill, campaign on behalf of the nation's poor women and a critical component of their overall reproductive health and rights. www.guttmacher.org