

**Hearing before the House Committee on Appropriations  
Subcommittee on 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***

**Testimony Submitted by:  
Madeline T. Morcelle, JD, MPH  
Staff Attorney, Reproductive and Sexual Health  
National Health Law Program**

**December 8, 2020**

The National Health Law Program (NHeLP) submits this testimony to the House Committee on Appropriations' Subcommittee on Labor, Health and Human Services, Education, and Related Agencies. Founded in 1969, NHeLP educates, advocates, and litigates to protect and advance the health rights of low-income and underserved people to access quality health care. We advocate for Medicaid policies and laws from coast to coast that meet the needs of low-income individuals and others who face systems of oppression that harm their health, such as women; Lesbian, Gay, Bisexual, Transgender, Queer [or Questioning], Intersex, and Gender Non-conforming (LGBTQI-GNC) people; Black, Indigenous, People of Color (BIPOC); immigrants; and people with disabilities. We also protect and enforce the rights of Medicaid enrollees in the courts.

We also advocate for a seamless system of comprehensive, quality, and affordable health care that includes the full spectrum of reproductive and sexual health services. That spectrum includes family planning and pregnancy-related care, including abortion, an essential health care service. We apply a reproductive justice framework in

our advocacy and analysis, exposing and fighting the systems of oppression that affect a person's ability to make health decisions about their body, sexuality, health, and reproductive future. NHeLP's testimony for this hearing addresses how the Hyde Amendment's de facto ban on federal abortion funding withholds access to an essential health care service, threatening the health, lives, and economic wellbeing of Medicaid enrollees and their families.

### **I. Importance of abortion access for Medicaid enrollees**

Medicaid is the nation's largest public health insurance program. As of July 2020, it covered more than one in five (nearly sixty-nine million) people across fifty states and Washington D.C.<sup>1</sup> Medicaid covers one in five women of reproductive age (15–49 years).<sup>2</sup> In 2018, half of women below the Federal Poverty Level (FPL) were insured by Medicaid.<sup>3</sup> Accordingly, it has long served as one of the most important sources of reproductive health care for people with low incomes, and is the single largest source of public funding for family planning services and supplies.<sup>4</sup> Medicaid is an especially vital lifeline for BIPOC, survivors of intimate partner violence, and LGBTQI-GNC people, who

---

<sup>1</sup> *July 2020 Medicaid & CHIP Enrollment*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html> (last visited Dec. 3, 2020).

<sup>2</sup> The National Health Law Program recognizes that in addition to women, trans, intersex, genderfluid, and gender non-conforming individuals may experience pregnancy, and that all people have reproductive health needs. In this testimony and throughout our policy advocacy, education, and litigation, we use the word "woman" when necessary to accurately reflect the scope of research that focuses solely on women. We also use "women" to reflect statutory language. More inclusive data and analysis, as well as statutory, regulatory, and other language, are needed. See Alina Salganicoff et al., *The Hyde Amendment and Coverage for Abortion Services*, KFF (Sep 10, 2020), <https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services/>.

<sup>3</sup> *Id.*

<sup>4</sup> See Adam Sonfield, *The Central Role of Medicaid in the Nation's Family Planning Effort*, GUTTMACHER INST. 7, 10 (2012), <http://www.guttmacher.org/pubs/gpr/15/2/gpr150207.pdf> (stating that Medicaid provides 75% of public funding for family planning services and supplies).

are even more likely to live in poverty. BIPOC are especially likely to be enrolled in Medicaid and therefore lack coverage for most abortion care. For example, 31 percent of Black women of reproductive age and 27 percent of Latinx women of reproductive age nationally are enrolled in Medicaid, compared to 16 percent of their white counterparts.<sup>5</sup>

Abortion is an essential component of comprehensive health care. It is a safe, common, effective, and necessary medical intervention that ends pregnancy (See Appendix). Abortions are among of the safest medical procedures in the United States. They are safer than childbirth at every stage of gestation: the risk of death associated with childbirth is approximately fourteen times higher than the risk of death associated with abortion.<sup>6</sup> Mifepristone, which is used in combination with misoprostol in the recommended medication abortion regimen, is safer than Tylenol, Penicillin, Viagra, and other common and widely used medications.<sup>7</sup> Abortion is also common. One in four women will have an abortion by the age of forty-five.<sup>8</sup>

Abortion coverage is especially important for pregnant Medicaid enrollees, who, as low-income people, are more likely to experience unintended pregnancies and need

---

<sup>5</sup> See Adam Sonfield, *Why Protecting Medicaid Means Protecting Sexual and Reproductive Health*, 20 GUTTMACHER POL'Y REV. 39, 40 (2017), <https://www.guttmacher.org/gpr/2017/03/why-protecting-medicaid-means-protecting-sexual-and-reproductive-health>.

<sup>6</sup> Elizabeth Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2) OBSTETRICS & GYNECOLOGY 215–219 (Feb. 2019), [https://journals.lww.com/greenjournal/Fulltext/2012/02000/The\\_Comparative\\_Safety\\_of\\_Legal\\_Induced\\_Abortion.3.aspx](https://journals.lww.com/greenjournal/Fulltext/2012/02000/The_Comparative_Safety_of_Legal_Induced_Abortion.3.aspx).

<sup>7</sup> See *Issue Brief: Analysis of Medication Abortion Risk and the FDA Report "Mifepristone U.S. Post-Marketing Adverse Events Summary through 12/31/2018"*, ADVANCING NEW STANDARDS IN REPROD. HEALTH (Apr. 2019), [https://www.ansirh.org/sites/default/files/publications/files/mifepristone\\_safety\\_4-23-2019.pdf](https://www.ansirh.org/sites/default/files/publications/files/mifepristone_safety_4-23-2019.pdf).

<sup>8</sup> See *Fact Sheet: Induced Abortion in the United States*, GUTTMACHER INST. (Jan. 2018), <https://www.guttmacher.org/fact-sheet/induced-abortion-united-states>.

access to abortion care. A person living in poverty is more than five times as likely as one not living in poverty to experience an unintended pregnancy.<sup>9</sup> Medicaid enrollees, who are by definition low-income, are more likely to experience gaps in contraception use that put them at higher risk of unintended pregnancy compared to individuals who have other forms of insurance.<sup>10</sup> Unintended pregnancy is more common among communities of color, contributing to higher than average abortion rates.<sup>11</sup> As well, LGBTQI-GNC people are more likely to be living in poverty and to need access to abortion care.<sup>12</sup> People with incomes under 100 percent of the FPL accounted for nearly half of all abortion patients in 2014.<sup>13</sup> As incomes increase, abortion rates decrease, with women in the highest income bracket experiencing an abortion rate less than half the national rate.<sup>14</sup>

---

<sup>9</sup> See Lawrence B. Finer & Mia R. Zolna, *Unintended Pregnancy in the United States: Incidence & Disparities*, 2006, 84 CONTRACEPTION 478, 483 (2011), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3338192/>.

<sup>10</sup> Jennifer J. Frost et al., *Factors Associated with Contraceptive Use and Nonuse, United States, 2004*, 39 PERSPECTIVES ON SEXUAL & REPROD. HEALTH 90, 93 (2007), <https://onlinelibrary.wiley.com/doi/abs/10.1363/3909007?sid=nlm%3Apubmed>.

<sup>11</sup> See, e.g., Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008–2011*, 374 NEW ENG. J. MED. 843 (2016).

<sup>12</sup> M.V. Lee Badgett et al., *New Patterns of Poverty in the Lesbian, Gay, and Bisexual Community*, WILLIAMS INST. 2 (2013), <https://williamsinstitute.law.ucla.edu/publications/lgb-patterns-of-poverty/>; see also Jennifer Russomanno et al., *Food Insecurity Among Transgender and Gender Nonconforming Individuals in the Southeast United States: A Qualitative Study*, 4 TRANSGENDER HEALTH 89 (2019), <https://www.liebertpub.com/doi/10.1089/trgh.2018.0024>; Bethany G. Everett et al., *Sexual Orientation Disparities in Mistimed and Unwanted Pregnancy Among Adult Women*, 49 PERSPECTIVES ON SEXUAL & REPROD. HEALTH 157, 161 (2017), <https://pubmed.ncbi.nlm.nih.gov/28598550/>. Presumably, members of this group end unintended pregnancies at rates consistent with the national average. Caroline S. Hartnett et al., *Congruence across Sexual Orientation Dimensions and Risk for Unintended Pregnancy among Adult U.S. Women*, WOMEN'S HEALTH ISSUES (2016), <https://www.sciencedirect.com/science/article/abs/pii/S1049386716303085>.

<sup>13</sup> See Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, AM. J. OF PUB. HEALTH (Dec. 2017), <https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304042>.

<sup>14</sup> *Id.* (noting that the abortion rate for women in the highest income group is 6 per 1,000).

Abortion care access is a critical means of keeping families from slipping further into poverty. Economic instability and the inability to financially care for a child are leading reasons that many low-income pregnant people seek abortion care. About 73 percent of abortion patients indicate that they are seeking an abortion because they cannot afford to have a child.<sup>15</sup> About 60 percent of people seeking abortion care already parent at least one child.<sup>16</sup>

## II. The Hyde Amendment is a de facto abortion ban for Medicaid enrollees

Although Medicaid covers most pregnancy-related services, the Hyde Amendment singles out and excludes abortion. Since it was first implemented in 1977, the Hyde Amendment has blocked federal funding for abortion except in extremely rare circumstances. The current version of the budget rider prohibits the use of Medicaid, Medicare, Indian Health Service, Federally Qualified Health Center, and other federal health program funds for abortion except when the pregnancy is the result of rape or incest or the pregnant individual's life is at risk because of the pregnancy.<sup>17</sup>

As reproductive justice advocates and scholars have held in the decades since its initial enactment, the Hyde Amendment was designed to stop people living in poverty from having abortions, creating a de facto ban that would strip people of their

---

<sup>15</sup> Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 PERSPECTIVES ON SEXUAL & REPROD. HEALTH 110 (2005), <https://www.guttmacher.org/journals/psrh/2005/reasons-us-women-have-abortions-quantitative-and-qualitative-perspectives>; see also M. Antonia Biggs et al., *Understanding Why Women Seek Abortions in the U.S.*, 13 BMC WOMEN'S HEALTH 29 (2013), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3729671/>.

<sup>16</sup> See Karen Pazol et al., *Ctrs. for Disease Control and Prevention, Abortion Surveillance—United States, 2009*, 61 MMWR SURVEILL. SUMM. 1, 7 (Nov. 23, 2012), <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6108a1.htm>.

<sup>17</sup> Department of Defense and Labor, Health and Human Services, and Education Appropriations Act of 2019 and Continuing Appropriations Act of 2019, Pub. L. No. 115-245, 132 Stat. 2981, 3118, §§ 506-07 (2018).

constitutionally-protected reproductive rights.<sup>18</sup> Representative Henry Hyde, the sponsor who first introduced and long championed the Amendment, laid bare his intent to forestall people who have low-incomes from obtaining abortion care, stating:

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.<sup>19</sup>

The Hyde Amendment works as intended, harming the health, financial security, and overall wellbeing of Medicaid enrollees, patients in other vital federal health care programs, and their families.

Because of the Hyde Amendment, Medicaid abortion coverage hinges on the enrollee's location. Although state Medicaid programs may use state dollars to cover abortions beyond the Hyde Amendment's restrictive exceptions, only sixteen do so.<sup>20</sup> For Medicaid enrollees in the thirty-four states and the District of Columbia who only cover abortions within Hyde's exceptions, this budget rider creates a de facto ban on abortion coverage.

Since its enactment, the Hyde Amendment has banned abortion coverage for millions of people. To illustrate, if Congress ended the ban in 2018, it would have provided federal support for abortion coverage for 14.2 million reproductive-age women enrolled in Medicaid and millions of others in similarly restricted federal health care

---

<sup>18</sup> See *Two Sides of the Same Coin: Integrating Economic & Reproductive Justice*, REPROD. HEALTH TECH. PROJ. (Aug. 2015), <http://rhtp.org/wp-content/uploads/2016/08/Two-Sides-of-the-Same-Coin-Integrating-Economic-and-Reproductive-Justice.pdf>; Jill E. Adams & Jessica Arons, *A Tragedy of Justice: Revisiting Harris v. McRae*, 21 WM. & MARY J. WOMEN & L. 5 (2014).

<sup>19</sup> 123 CONG. REC. 19,700 (1977) (statement of Rep. Hyde).

<sup>20</sup> *State Funding of Abortion Under Medicaid*, GUTTMACHER INST., Dec. 1, 2020, <https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid>.

programs.<sup>21</sup> In particular, ending Hyde could have broadened abortion coverage for 7.7 million women enrolled in Medicaid in the states that do not use their own funds to cover abortions beyond Hyde's rare exceptions.<sup>22</sup> Low-income BIPOC and LGBTQI-GNC people are more profoundly and extensively impacted by the Hyde Amendment due to disproportionate rates of poverty in these communities.<sup>23</sup> Nationally, BIPOC are disproportionately low-income. According to 2019 Census estimates, 21.2 percent of Black, 23 percent of American Indian and Alaska Natives, 17.2 percent of Latinx or Hispanic individuals, and 16.5 of Native Hawaiian or Pacific Islander individuals are living below the poverty level, compared with only 9 percent of white people and 9.6 percent of Asian Americans.<sup>24</sup>

The Hyde Amendment elevates the financial hurdles to abortion access already experienced by pregnant people living in poverty. The majority must pay out-of-pocket costs for abortion care, and the costs are prohibitively high for people living below the FPL. Moreover, obtaining abortion care creates additional costs including lost wages, child care, gas or other travel expenses, and overnight stays. More than half of Turnaway Study participants nationwide had to spend more than one-third of their

---

<sup>21</sup> Although an estimate is only available for women at this time, more inclusive data are needed to reflect all those harmed by the Hyde Amendment's ban on abortion coverage, including women, trans, gender non-conforming, non-binary, and intersex Medicaid enrollees. Salganicoff et al., *supra* note 2.

<sup>22</sup> *Id.*

<sup>23</sup> Badgett et al., *supra* note 12; see also Russomanno et al., *supra* note 12.

<sup>24</sup> *Poverty Status in the Last 12 Months*, U.S. CENSUS BUREAU, <https://data.census.gov/cedsci/table?q=poverty&tid=ACSSST1Y2019.S1701&hidePreview=true> (last visited Dec. 6, 2020).

monthly income to cover total out-of-pocket costs (e.g., abortion care and travel).<sup>25</sup> This number was closer to two-thirds for those receiving later abortions.<sup>26</sup>

By denying health insurance coverage for abortion care and treating it differently than other essential health services, the Hyde Amendment coerces low-income people in public health insurance programs such as Medicaid to continue pregnancies that they would otherwise elect to end. Without abortion coverage, low-income pregnant people are forced to choose between saving up for an abortion by forgoing rent, utilities, groceries, prescriptions, and other necessities, or carrying a pregnancy to term.<sup>27</sup> More than half of women in the Turnaway Study reported that raising money for an abortion delayed obtaining care.<sup>28</sup> Often, low-income pregnant people cannot scrape together the necessary funds in time before reaching gestational limits on abortion access.<sup>29</sup> Consequently, funding restrictions such as the Hyde Amendment force many Medicaid-eligible individuals to carry pregnancies to term against their will. One study found that lack of funding forces about a quarter of Medicaid-eligible women to continue an unintended pregnancy to term against their will.<sup>30</sup>

---

<sup>25</sup> See Sarah C.M. Roberts et al., *Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States*, 24 WOMEN'S HEALTH ISSUES 211(2014), <https://www.ncbi.nlm.nih.gov/pubmed/24630423>.

<sup>26</sup> *Id.*

<sup>27</sup> See *id.*; Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am. J. Pub. Health 407, 412 (2018).

<sup>28</sup> See Sarah C.M. Roberts et al., *supra* note 25 at 211.

<sup>29</sup> One study determined that, on average, one in four low-income people are forced to carry an unintended pregnancy to term who would have instead accessed abortion if they could afford to do so. Stanley K. Henshaw et al., *Restrictions on Medicaid Funding for Abortion: A Literature Review*, GUTTMACHER INST. (2009), <https://www.guttmacher.org/report/restrictions-medicaid-funding-abortions-literature-review>.

<sup>30</sup> See Diana Green Foster & M. Antonia Biggs, *Effect of an unwanted pregnancy carried to term on existing children's health, development and care*, ADVANCING NEW STANDARDS IN REPROD. HEALTH, <https://doi.org/10.1016/j.jpeds.2018.09.026>.



### III. The Hyde Amendment threatens the lives and health of pregnant Medicaid enrollees

The Hyde Amendment has grave risks and long-lasting ramifications for pregnant people unable to obtain the care they need. Evidence clearly demonstrates that if a person seeks abortion and access is denied, they are at greater risk of experiencing negative health outcomes. For example, the risk of death associated with carrying a pregnancy to term is, on average, about fourteen times higher than that with abortion.<sup>31</sup> People who give birth after being denied abortion care experience more potentially life-threatening complications, such as preeclampsia and postpartum hemorrhage.<sup>32</sup> People who are denied abortions are also at risk of death from conditions that are more fatal for pregnant people. For example, a woman who was denied an abortion and enrolled in the Turnaway Study, which examines the effects of unwanted pregnancy and abortion on women's lives across the United States, died from a condition that presents a higher risk of death among pregnant people.<sup>33</sup> In addition, people who give birth after being denied abortions report more chronic pain and rate their overall health status as worse.<sup>34</sup>

---

<sup>31</sup> See Elizabeth G. Raymond & David A. Grimes, *supra* note 6.

<sup>32</sup> Lauren J. Ralph et al., *Self-reported Physical Health of Women Who Did and Did Not Terminate Pregnancy After Seeking Abortion Services: A Cohort Study*, 173(5) ANN. INTERN. MED. 238–247 (Aug. 2019), <https://pubmed.ncbi.nlm.nih.gov/31181576/>; See Caitlin Gerdtts et al., *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy*, 26 WOMEN'S HEALTH ISSUES 55, 57 (2016), <https://pubmed.ncbi.nlm.nih.gov/26576470/>.

<sup>33</sup> *Id.*

<sup>34</sup> Lauren J. Ralph et al., *supra* note 32 at 247; See Caitlin Gerdtts et al., *supra* note 32.

Pregnant and postpartum BIPOC face a disproportionate risk of pregnancy-related mortality compared to pregnant and postpartum white people.<sup>35</sup> From 2007–2016, pregnancy-related deaths were highest for Black and Indigenous women (40.8 and 29.7 per 100,000 births), at rates 3.2 and 2.3 times higher than those experienced by white women (12.7).<sup>36</sup> By denying abortion access, the Hyde Amendment contributes to the United States' Black and Indigenous maternal mortality crises.

#### **IV. The Hyde Amendment's economic harms are significant and long lasting**

Those who seek but are unable to secure abortions are significantly more likely to experience long-term poverty than those able to obtain abortion care.<sup>37</sup> Data from the Turnaway Study demonstrates that the denial of abortion has significant and long lasting economic harms for pregnant people and their families, including increased odds of falling below FPL, more debt, lower credit scores, and worse financial security for years after the pregnancy.<sup>38</sup>

---

<sup>35</sup> See Elizabeth G. Raymond & David A. Grimes, *supra* note 6; Sarah J. Holdt Somer et al., *Epidemiology of Racial/Ethnic Disparities in Severe Maternal Morbidity and Mortality*, 41 SEM, IN PERINATOLOGY 258 (2017), <https://pubmed.ncbi.nlm.nih.gov/28888263/> (noting that in the U.S. racial and ethnic disparities in maternal mortality are extreme); Emily Petersen et al., *Racial/Ethnic Disparities in Pregnancy-Related Deaths—United States, 2007–2016*, 68(35) MORBIDITY & MORTALITY WEEKLY REP. 762, 764 (Sep. 6, 2019), <https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm> (discussing the role of institutional and interpersonal racism in pregnancy-related deaths).

<sup>36</sup> *Id.* at 762. More inclusive data collection is needed to illustrate the issue as it impacts LGBTQI-GNC individuals who experience pregnancy.

<sup>37</sup> See Foster et al., *supra* note 27 at 412.

<sup>38</sup> Sarah Miller et al., *The Economic Consequences of Being Denied an Abortion*, Working Paper 26662, Nat'l. Bureau of Econ. Research (Jan. 2020) <https://www.nber.org/papers/w26662>; Diana Greene Foster et al., *supra* note 27 at 413; Sarah Miller, *What Happens After an Abortion Denial? A Review of Results From The Turnaway Study*, 110 AEA PAPERS & PROCEEDINGS 226–230 (May 2020), <https://www.aeaweb.org/articles?id=10.1257/pandp.20201107>.

Ensuring abortion access enables people to achieve goals related to education, employment, and a wanted change in residence.<sup>39</sup> The Turnaway Study showed that women who receive abortions are six times more likely to have positive plans for the next year and are more likely to achieve them.<sup>40</sup> Those who are denied abortions are less likely to obtain college degrees. Achieving life plans and educational goals can result in improved economic security and, in turn, health.<sup>41</sup> In contrast, the economic impact of not being able to obtain an abortion is compounded by the health risk of carrying an unintended pregnancy to term.

When people have control over the timing of having children, existing and future children benefit. The Turnaway Study showed that children born later to women who are able to receive abortions experience greater economic security and maternal bonding than those born because abortions are denied.<sup>42</sup>

#### **V. Ending the Hyde Amendment could encourage health insurance issuers who have adopted similar funding restrictions to end them**

---

<sup>39</sup> See Ushma D. Upadhyay et al., *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15(102) BMC WOMEN'S HEALTH 1–10 (Nov. 2015), <https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-015-0259-1>.

<sup>40</sup> *Id.*; Lauren J. Ralph et al., *A Prospective Cohort Study of The Effect Of Receiving Versus Being Denied an Abortion On Educational Attainment*, 29(6) WOMEN'S HEALTH ISS. 455–464 (November 2019) <https://pubmed.ncbi.nlm.nih.gov/31708341/>; Molly A. McCarthy et al., *The Effect of Receiving Versus Being Denied an Abortion On Having and Achieving Aspirational Five-Year Plans*, 46(3) BMJ SEXUAL & REPROD. HEALTH 177–183 (2020), <https://pubmed.ncbi.nlm.nih.gov/32098771/>.

<sup>41</sup> Michael Marmot, *The Influence of Income on Health: Views of An Epidemiologist*, 21(2) HEALTH AFFAIRS 31–46 (March–Apr. 2002), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.21.2.31>.

<sup>42</sup> Diana G. Foster et al., *Comparison of Health, Development, Maternal Bonding, & Poverty Among Children Born After Denial of Abortion vs. After Pregnancies Subsequent to an Abortion*, 172(11) JAMA PEDIATRICS, 1053–1060 (2018), <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2698454>; Diana G. Foster et al., *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, 205 J. of Pediatrics 183–189 (Oct. 2018), [https://www.jpeds.com/article/S0022-3476\(18\)31297-6/fulltext](https://www.jpeds.com/article/S0022-3476(18)31297-6/fulltext).

The Hyde Amendment's language imposing abortion funding restrictions has seeped into health programs and plans beyond the legal reach of the budget rider. For example, according to a 2019 NHeLP analysis, some Marketplace plans incorporate the Hyde Amendment's harmful restrictions on abortion coverage even though they are not legally obligated to do so.<sup>43</sup> Eliminating the Hyde Amendment could encourage health insurance issuers to cover abortions just as they would any other safe, common, and essential health care service.

## VI. Conclusion

As national and global health leaders from the American College of Obstetricians and Gynecologists to the World Health Organization attest, safe and legal abortion care is a necessary component of comprehensive health care and access is essential for the attainment of the highest possible level of sexual and reproductive health.<sup>44</sup> Until the United States ends the Hyde Amendment and ensures that abortion care is covered under all health insurance programs and plans, including Medicaid, millions will continue to lack access and their health and wellbeing will suffer. The future of health equity is only as bright as the future of reproductive justice. It is time for Congress to secure abortion coverage for all, no matter a person's health insurance program or plan, location, race or ethnicity, sexual orientation, disability, gender identity, age, language, or economic status.

---

<sup>43</sup> Fabiola Carrión & Alexis Robles-Fradet, *Beyond the Law: The Challenge of Marketplace Coverage of Abortions*, NAT'L HEALTH L. PROG. (Aug. 7, 2019), <https://healthlaw.org/resource/beyond-the-law-the-challenge-of-marketplace-coverage-of-abortions/>.

<sup>44</sup> See, e.g., *Committee Opinion 815: Increasing Access to Abortion*, ACOG (Dec. 2020) <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/12/increasing-access-to-abortion>; *Abortion*, WORLD HEALTH ORG., [https://www.who.int/health-topics/abortion#tab=tab\\_1](https://www.who.int/health-topics/abortion#tab=tab_1) (last visited Dec. 3, 2020).

**Appendix: Abortion is Health Care**



# Abortion is Health Care

Alexis Robles-Fradet, MPH

## I. Brief History of Abortion in the United States

The United States did not always have a history of [imposing restrictions on abortion](#). Until the early 1800s, abortion was legal before a [pregnant person felt fetal movement](#), known as “quickening.” Midwives and other healers largely supervised and assisted with abortion care.

The shift towards banning abortions was born out of racism, misogyny, and the desire for control. [In the mid-1800s](#), the United States experienced a shift towards criminalizing abortion. This was [followed by](#) a move away from midwifery and traditional medicine typically performed by women in their communities in favor of the relatively new, profitable, and male-dominated Western medicine model in the early 1900s. [Black midwives and healers](#) were condemned for performing abortions as well as for their care of pregnant people. The desire for control over pregnancy and reproduction was motivated in part by the [declining birthrates](#) of white Protestant American women in the late 1800s and increased migration. During this time, abortions continued but in much more unsafe conditions unless one was able to [travel to and pay](#) the few providers who performed abortions safely.

In 1973, the Supreme Court decision in *Roe v. Wade* confirmed that the decision to [terminate a pregnancy is a constitutional right](#). Three years later, Congress passed an appropriations bill rider known as the [Hyde Amendment](#) in order to block federal funds from being used to pay for abortion outside of the narrow scope of rape, incest, and life endangerment. The Hyde Amendment and many other restrictions that followed have severely limited coverage for abortion for those enrolled in Medicaid and other federal programs. Since then, [states have enacted a maze of abortion-related laws](#) that limit when, where, and under what circumstances one can obtain an abortion.

## II. Abortion is Health Care<sup>1</sup>

Abortions are common medical interventions that end pregnancies. Abortions occur regardless of whether it is legal or not to obtain one. [The Guttmacher Institute](#) reports that in 2017 the abortion rate in countries that prohibit or limit abortion was 37 per 1,000 people and that the abortion rate was 34 per 1,000 people in countries that broadly allow for abortion. [The World Health Organization](#) (WHO) confirms that criminalizing abortion does not stop abortions but only makes them less safe; unsafe abortions lead to 4.7 percent to 13.2 percent of maternal deaths.

Various abortion methods can be used to end pregnancies, including medication abortion and surgical abortion. The different procedures for abortions depend on personal preference, length of pregnancy, availability, and access. According to data from the Centers for Disease Control (CDC), in 2016, [almost two-thirds](#) (65.5 percent) of abortions occurred at eight or less weeks of gestation and most (91.0 percent) occurred in the [first trimester](#) or up to thirteen weeks of pregnancy.

Medication abortions involve taking two medications: mifepristone and misoprostol. Mifepristone [blocks progesterone](#), which is a hormone needed for a pregnancy to grow normally. The second medication, [misoprostol, is taken up to 48 hours later](#). Misoprostol causes the uterus to empty, typically resulting in what [feels like a heavy menstruation](#). Medication abortions work up to [70 days](#) or eleven weeks after the first day of the last menstrual cycle. Mifepristone is included by the WHO on their [Model List of Essential Medicines](#). The U.S. Food and Drug Administration (FDA) [allows patients](#) to take mifepristone and misoprostol at home with the choice of self-assessment or clinical follow-up to determine success of the medication abortion.

Mifeprex, the brand name of mifepristone, is subject to regulations known as the [Risk Evaluation and Mitigation Strategy](#) (REMS). Under the REMS requirements, healthcare providers must be certified in the REMS Program and Mifeprex must be dispensed at certain healthcare settings. [The American College of Obstetricians and Gynecologists \(ACOG\) opposes these restrictions](#) and [research shows](#) that there is no significant need for them; for example, there is no difference between self-assessment and clinical follow-up in determining that medication abortion was successful. ACOG also recognizes that medication abortions can be safely provided through [telemedicine](#). The [use of telemedicine](#) can greatly increase access to abortion for those without access to a health care provider. In fact, in an [analysis](#) of nearly 20,000 medication abortions, the rare occurrence of adverse reactions did not differ between in-person care and telemedicine.

Other types of abortion procedures are considered [surgical abortions](#). There is [no standard terminology for these types of abortion](#) which include methods like [uterine aspiration](#),

---

<sup>1</sup> This report will occasionally use the terms “women” or “woman” as well as other gendered language where the research data or laws cited uses those specific terms. We recognize that people of all genders, gender identities, and expressions require access to abortion and have tried to otherwise limit our use of gendered language where possible.



aspiration curettage, suction curettage, dilation and curettage, dilation and evacuation. Surgical abortion options depend on the stage of pregnancy, geographical location, and what tools are used, e.g. if curettage instrument is not used, it would not be included in the name. [Uterine aspiration abortion](#) is common. According to the CDC, in 2016, approximately 59.9 percent of abortions were surgical and performed at or before 13 weeks of pregnancy. Aspiration is usually [performed in the first trimester](#). The procedure typically involves a mechanical or medication cervical dilator followed by a [mechanical vacuum aspirator](#). In the second trimester, [dilation and evacuation](#) is the most commonly used method in the United States. This method entails dilation of the cervix with medication or mechanical dilators followed by the evacuation of the contents of the uterus with suction, forceps, or curettage to empty the uterus; this method is usually used after sixteen weeks [since the last menstrual cycle](#). The [CDC reports](#) that only 1.2 percent of abortion are performed at 21 weeks or later.

The National Academies of Science, Engineering, and Medicine confirmed in 2018 that [abortions are safe and low-risk interventions](#). Also according to [ACOG](#), the risk of death from abortion is lower than one in 100,000 and the risk of dying in childbirth is fourteen times greater than the risk of dying from an early abortion. Complications from medication abortion are rare as well, occurring in [less than one percent](#) of patients. Similarly, complications are also rare in aspiration abortions. One study analyzed Medicaid claims data in California and found that 0.16 percent of approximately 35,000 patients were found to have experienced serious complications. With dilation and evacuation methods, the risk is increased due to increased stage of pregnancy. Despite this increase, the [rate of complication is still low](#), ranging from 0.05 to 4 percent.

Physicians are not the only providers who are able to perform or assist in an abortion. Nurse practitioners, certified nurse-midwives, and physician assistants can perform abortions and increasingly are legally permitted to do so. A six year study, [Health Workforce Pilot Project](#), demonstrated that these providers can safely and competently provide early abortion care. In 2003, [the WHO recommended](#) that abortion services can be provided at the lowest appropriate level of health care systems, stating specifically that aspiration abortion can be completed up to twelve weeks of pregnancy by mid-level health providers like midwives, nurse practitioners, clinical officers, physician's assistants, and others with the appropriate training. [ACOG encourages](#) abortion education expansion to increase the number and types of trained providers who can improve access to safe abortions.

People from all demographics get abortions, regardless of income, sex and gender, race, geographic location, disability, or marital status. Abortions are not limited to cisgender heterosexual women. [The Guttmacher Institute](#) shows the racial demographics of abortion patients in 2014 was as follows: 39 percent were white, 28 percent Black, 25 percent Latinx, 6 percent Asian/Pacific Islander, and 3 percent were "Other." In addition, 62 percent of abortion patients were religiously affiliated, 59 percent were women with children, and 60 percent were people in their 20s. The Guttmacher Institute [also estimates](#) that in 2017, approximately 462 to 530 transgender and non-binary individuals obtained abortions and 23 percent of surveyed abortion clinics provided transgender-specific health services. [People with disabilities](#) often face more barriers to clinician access and reproductive and sexual health care in addition to enduring the double stigma of disability and stigma related to sexuality and abortion.



Many motives lead individuals to end their pregnancies. [One study](#) found that the most cited reasons for seeking an abortion were that having a child would interfere with a person's education, work, or ability to care for dependents (74 percent) that she could not afford a baby (73 percent), that she did not want to be a single parent or was having relationship issues (48 percent). In addition, four in ten women said that they had completed their childbearing, and about one-third of participants said they were not ready to have a child.

The organizations, [Shout Your Abortion](#) and [We Testify](#) compile accounts of people who have had abortions and their stories. These stories show the complexity and diversity of people who get abortions while helping to destigmatize the intervention.<sup>1</sup>

*We Testify*, in particular, elevates the voices of people of color, queer-identified people, those with varying abilities, and different citizenship statuses. One person, describes her experience with abortion as [a Black woman, HBCU graduate, and Christian](#): “I want fellow Christians to know that having abortions won’t separate you from the love of God. My faith played a major role in choosing abortion and being able to feel firm in my decision. [...] I want people to know that you don’t have to choose between your faith and your decision to have an abortion. For me, having an abortion actually strengthened my spiritual relationship.”

[Another storyteller](#) describes having an abortion at 20 as a “poor undergraduate student in a crumbling relationship with poor mental health... Making the decision to have an abortion wasn’t difficult, but accessing it was. I’m an AfroLatinx person with no health insurance. The medicinal abortion route was a smooth \$500 out of pocket and the whole time I was paying I was kissing my rent, textbooks, and groceries goodbye. [...] It wasn’t just the physical and logistical aspects of having a medicinal procedure, but the emotional labor of navigating a space where I was constantly misgendered. [...] I’ve made it a personal goal to shed light on how trans and gender nonconforming people are also very much affected by restrictive and oppressive anti-choice legislation.”

Telling stories sheds light on how experiences with abortion are varied and depend on one's circumstances, intersecting identities, and where one lives. Some people describe uncertainty in deciding to get abortions while others were positive from the moment they found out they were pregnant that they wanted an abortion. During and after the abortion experiences range from relief, to joy, to freedom, and sometimes sadness. One person describes [their decision to seek an abortion](#): “It was never a hard decision for me and I’d do it again. There was no pain, no tears, or feeling conflicted. I was pregnant and did not want to be. Simple as that and it was a valid reason. [...] Having autonomy over my own body is joyful and it is my right [...]” [Another story](#) states that “Abortion make (sic) me the person that I wanted to be.” In this story, the author describes their abusive relationship, and that for them, having a child would mean letting go of their dreams and raising a child with their abuser.<sup>2</sup> Another person describes feeling both relief and grief during their abortion: “In the days that followed I was surprised by the degree of sadness and loss I felt despite knowing it was the best possible outcome and something I actively chose. Grief and relief seemed a contradictory pairing, yet there they

---

<sup>2</sup> The singular they/them is used here as the pronouns of the storytellers are not available.

were, filling my heart together. I learned to give myself time and space to sit with this duality, to remind myself I can be pro-choice and thankful to no longer be pregnant while simultaneously mourn the loss of something I wanted under different circumstances.” These stories show that people seek abortions for many reasons and for many the ability to decide when to have a child is freedom, joy, and key for both their health and a potential child’s health.

### III. Abortion Restrictions are a Public Health Crisis

Restricting access to abortion has consequences for the mental, physical, and social health and well-being of people who can become pregnant. Restrictions happen through laws and policies that limit access, force clinics to close, make abortion unaffordable, spread misinformation about abortions, and stigmatize abortion.

[The Hyde Amendment](#) was introduced in 1976 and continues to be renewed by Congress every year. This appropriation bill rider prohibits coverage of abortion except in limited cases of rape, incest, or when a pregnancy is life endangering. The Hyde Amendment applies to crucial health coverage programs like Medicaid and Medicare as well as to individuals who receive health care coverage through the federal government like federal employees, military personnel and veterans, Indigenous people receiving health care through the Indian Health Service, and more.

Due to the Hyde Amendment, it is estimated that 7.4 million women ages 15-49 who are enrolled in Medicaid cannot use their insurance to cover the cost of abortion except in [very narrow circumstances](#). However, Medicaid does cover other services related to pregnancy such as prenatal care, treatment of complications after a medically unsupervised abortion, treatment of ectopic pregnancies, and post-abortion contraception. Similar restrictions can be found in some states’ Marketplace plans, private insurance plans, and employer plans. [Sixteen states](#) go beyond the Hyde Amendment to cover all abortions in their Medicaid programs using state funds.

Without insurance coverage of abortion, those seeking abortions must pay for it out-of-pocket. The cost varies based on location, type, and other factors but on average a first trimester abortion can [cost between \\$500 to over \\$1,000](#). In addition to out-of-pocket costs for the abortion itself, there are also costs associated with travel, childcare costs, and time off from work. Partly as a result of unnecessary restrictions on abortion care, the number of abortion providers is in [decline](#).

Many patients must travel long distances to obtain abortions. For example, even in a state with increased insurance coverage of abortion like California, abortion patients have travel burdens associated with abortion because providers are concentrated in urban areas. [One study](#) found that among women seeking an abortion in California who are enrolled in Medicaid, 11.9 percent traveled 50 miles or more. In addition, individuals obtaining second trimester or later abortions as well as rural residents have to travel 50 miles or more to obtain an abortion. [One study examined 6,022 telemedicine requests](#) for self-managed abortion services over ten months. They found that while approximately 76 percent of requests were from states with

hostile restrictions, the majority (60 percent) reported a combination of barriers to clinic access and preference for self-management of abortion for privacy and convenience.

The legal framework set forth in *Planned Parenthood of Southeastern Pennsylvania v. Casey* has allowed states to place some limitations on abortion after the first trimester. Nevertheless, some state bills, such as those that restrict abortions when there is cardiac activity, have been blocked by federal courts because they are unconstitutional. The reality is that cardiac activity, which can be detected around six weeks, happens before many people even know they are pregnant. In effect, these bills would ban most abortions and are primarily designed to test the current Supreme Court's willingness to undermine or overturn *Roe v. Wade*.

Some laws specifically target abortion providers. Known as [Targeted Regulation of Abortion Providers \(TRAP\)](#), these laws typically apply the state's standard for ambulatory surgical centers on abortion clinics even though abortions are much less risky, invasive, and typically do not use the same high levels of sedation that other surgeries require. Some TRAP laws also require physicians to have admitting privileges at a local hospital. By reducing access through the distance between clinics and the growing closure of abortion clinics, these laws complicate who is allowed to perform an abortion or even dispense mifepristone and misoprostol.

Denying access to abortions negatively impacts people's physical health, mental health, and economic stability. [The Turnaway Study](#) is the largest study that examines women's experiences with abortion and unwanted pregnancy in the United States. In this study, researchers tracked the health of approximately 870 participants who sought abortions. About [160 participants were denied abortions](#) because they exceeded their clinics' gestational limits. Participants who were denied abortions more often reported that their overall health was "fair" or "poor" in comparison to those who had an abortion, who reported that their health as "good" or "very good." In addition, women who were denied an abortion reported [more life-threatening complications](#) of pregnancy like eclampsia and postpartum hemorrhage. Women who were denied an abortion also reported [higher instances of chronic headaches, migraines, and joint pain](#) compared to those that received an abortion.

People seeking abortions experience a [wide range of emotions](#) related to having abortions. However, women denied abortions report their stress and anxiety at the highest levels when they are denied this service. [The Turnaway Study](#) looked at the differences in mental health and the nuance in experiences for those who received an abortion and those who were denied. Mental health harm was not associated with those who wanted and were able to receive abortions. Those who were denied abortions had higher rates of anxiety and low self-esteem approximately one week after the denial. However, those who received abortions and those who were denied had similar rates of depression and both groups reported a reduction in depression over five years. The researchers found that the most significant factors linked with depression after seeking an abortion were an existing history of mental health conditions, history of child abuse, and neglect. Similarly, women seeking abortions after their first trimester did not experience higher rates of depression, anxiety, or other mental health harm than women who were obtaining an abortion in their first trimester, and stress levels between the two groups were similar by six months post-abortion.

Abortion denial can also affect [relationship health and the wellbeing of children](#). Women who were denied abortions were more likely to stay in contact with a violent or abusive partner while women who received an abortion experienced less physical violence from their partner. After five years, women who were denied an abortion were more likely to raise their child alone without family members and male partners. The existing children of women who were denied abortions had worse childhood development compared to children of women who received an abortion. Further, an abortion denial is associated with poorer maternal bonding with the next child born, compared to a woman who received an abortion.

Finally, abortion denial is tied to the financial health of women seeking abortions. The Turnaway study also showed that children of women who were denied abortions were more likely to live below the federal poverty level than the next children born to women who received abortions. [Another study on the economic consequences of abortion](#) compared the credit reports of women who received abortions and women who were denied abortions. The researchers found that both groups had [similar financial trajectories](#) prior to seeking abortions. Those who were denied abortions were found to have a “large and persistent increase” in financial distress over several years. The group denied abortions had a 78 percent increase in debt that was 30 day or more past due and an 81 percent increase in negative public records like eviction. This impact can be seen up to five years after the birth for those who were denied abortions.

#### **IV. Conclusion**

Abortion is a common, safe, and effective medical intervention. Abortion care is a critical part of the right to body autonomy, and is key to the physical, emotional, and economic health of a person seeking an abortion and that of their current and future families. Restrictions on abortion harm people and have ripple effects that can last for years. It is also important to destigmatize and normalize abortion as well as normalize that transgender, non-binary, gender non-conforming people, lesbian, and bisexual people all have a need for accessible, equitable, and competent care when seeking abortions

[The EACH Woman Act](#) (HR 1692 and S 758), introduced in 2019 by Congresswomen Barbara Lee (D-CA), Jan Schakowsky (D-IL), and Diana DeGette (D-CO), and U.S. Senators Tammy Duckworth (D-IL), Kamala Harris (D-CA), Mazie Hirono (D-HI), and Patty Murray (D-WA) [requires insurance coverage for abortion for every woman, regardless of income or insurance type](#). The enactment of the EACH Woman Act can mark a significant step towards reproduction freedom for all.

The National Health Law Program believes that abortion is health care and should be covered and accessible like any other medical intervention. Abortions are only unsafe when they are inaccessible, restricted, and denied.