Fostering Equitable Access to Abortion Coverage: Reversing the Hyde Amendment

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The future of access to abortion services is at a crossroads.[1] The Biden-Harris administration and 117th Congress could commit to dismantling the injustices of the Trump-Pence years and long-standing systems of oppression, or they could retreat and maintain the status quo that so harms low-income and underserved communities.

The Trump-Pence administration spent four years relentlessly reshaping federal public policy and the federal judiciary, leaving a legacy of further-entrenched systems of oppression that obstruct health, well-being, and reproductive justice. The National Heath Law Program (NHeLP) recognizes that legacy in the COVID-19 pandemic, a historic economic recession, a deepening Black and Indigenous maternal health crisis, and state-sanctioned structural, institutional, and interpersonal white supremacist, xenophobic, sexist, transphobic, and homophobic violence. We recognize it in anti-choice lawmakers' efforts to exploit the pandemic to justify increasing barriers to abortion services.[2]

The United States also grapples with longstanding reproductive injustices. For forty-five years, the Hyde Amendment has withheld federal funds from covering abortion services in nearly all circumstances. It has erected unconscionable barriers to access for low-income and underserved people who receive health coverage or care through Medicaid, the Children's Health Insurance Program (CHIP), Medicare, the Indian Health Service (IHS), and other federal health care programs. It has pushed abortion access out of reach for millions.

This constellation of reproductive injustices, new and old, has particularly harmed Black, Indigenous, and other people of color (BIPOC), lesbian, gay, bisexual, transgender, queer, intersex, and gender-nonconforming (LGBTQI-GNC) people, people with disabilities, young people, and those who live and experience compounded discrimination at the intersection of multiple identities. In turn, these injustices have elevated the need for equitable, holistic, and community-driven solutions that ensure access to sexual and reproductive health care services, including coverage of abortion services, for all.

NHeLP believes that abortion services should be covered for all, no matter a person's health insurance program or plan; location; race or ethnicity; sexual orientation; gender identity; age; language; or disability, immigration, or economic status. Congress should restore comprehensive abortion coverage in Medicaid and other federal health care programs by

ending the Hyde Amendment. Moreover, it should restore or otherwise require, and create a statutory right to, coverage of abortion services for people in federal health care programs by enacting the Equal Access to Abortion Coverage in Health Insurance (EACH) Act of 2021.[3]

This issue brief provides a brief history of the Hyde Amendment and examines its function as a de facto ban on abortion services for people who receive health coverage or care through federal health care programs and plans. Because the Hyde amendment initially focused on Medicaid, this issue brief explores the history of that de facto ban and examines the Hyde Amendment's long-lasting and significant public health and economic harms to low-income and underserved people. Finally, it provides an overview of the EACH Act of 2021.

The Hyde Amendment is a De Facto Abortion Ban

Since 1976, the Hyde Amendment has withheld federal funds from covering abortion services in nearly all circumstances. Congress renews this ban annually through the federal appropriations process. The current version of the Hyde Amendment prohibits the use of federal funds to cover abortions except when a pregnancy is the result of rape or incest, or a person's life is at risk because of a pregnancy.[4] Today, Hyde withholds coverage of abortion services from people:

- Enrolled in Medicaid, CHIP, and Medicare;[5]
- Who receive health care from IHS;
- Detained in federal facilities, such as federal prisons and immigration detention; and
- Who are enrolled in government-sponsored health insurance plans due to an employment relationship, such as federal employees and their dependents, Peace Corps volunteers; military members, veterans, and their dependents.

The Hyde Amendment elevates the financial hurdles to abortion access already experienced by pregnant people experiencing poverty. Without health coverage for abortion services, the majority must pay out-of-pocket to access care, and costs are prohibitively high for people living near the Federal Poverty Level (FPL). Without abortion coverage, pregnant people with low incomes are forced to choose between saving for an abortion by forgoing rent, utilities, groceries, prescriptions, and other necessities, or carrying a pregnancy to term.[6] Moreover, accessing abortion services often involves additional costs such as lost wages, childcare, travel expenses, and overnight stays. More than half of participants in the Turnaway Study, which examines the effects of unwanted pregnancy and abortion on women's lives across the United States, had to spend more than one-third of their monthly income to cover total out-of-pocket costs (*e.g.*, abortion services and travel).[7] This number was closer to two-thirds for those receiving later abortions.[8]

By denying health insurance coverage for abortion services and treating them differently than other essential health care, the Hyde Amendment coerces many low-income and underserved people who receive health insurance coverage or care through the federal government to continue pregnancies they wish to end. More than half of women in the Turnaway Study

reported that raising money for abortions delayed obtaining care.[9] In 2018, thirty-nine percent of Americans did not have enough savings to pay for a $400 emergency expense such as an abortion, the cost of which increases as care is delayed.[10] That number likely increased amid the COVID-19 pandemic and related economic recession. Often, pregnant people with low incomes cannot scrape together the necessary funds in time before reaching gestational limits on abortion access.[11]

Comprehensive health coverage cannot be achieved absent comprehensive coverage of abortion services.[12] By singling out and imposing a ban on federal funding for abortion services, the Hyde Amendment withholds comprehensive health coverage from millions. Because white supremacy, xenophobia, ableism, sexism, transphobia, ableism, and other intersecting systems of oppression are designed to fuel poverty, BIPOC, LGBTQI-GNC people, people with disabilities, and young people are disproportionately likely to receive health coverage or care through Medicaid, CHIP, IHS, and other federally-funded programs subject to the Hyde Amendment.[13] For example, 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 FPL, compared with only 9 percent of white people.[14]

Medicaid, CHIP, and the Hyde Amendment

As reproductive justice advocates and scholars have stressed for decades, the Hyde Amendment was designed to stop Medicaid enrollees from having abortions and create a de facto ban that would strip people of their constitutionally protected reproductive rights.[15] Representative Henry Hyde, the sponsor who first introduced and long championed the Amendment, explicitly expressed this intent when he stated:

> 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.[16]

Representative Hyde would have preferred a universal abortion ban, but the vehicle available to him was, and continues to be, far-reaching. Medicaid is the nation's largest public health insurance program.[17] In 2018, half of all women below the FPL were insured by Medicaid.[18]

Although state Medicaid and CHIP programs may use state dollars to cover abortions beyond the Hyde Amendment's restrictive exceptions, in practice, only sixteen do so.[19] Congressional appropriators specifically block Washington, DC from expending its own funds to cover abortion services except within Hyde's extremely limited exceptions.[20] For Medicaid and CHIP enrollees in the thirty-four states and DC 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 federal funding for abortion coverage for millions of people enrolled in Medicaid and CHIP. If Congress ended the ban in 2018, federal funding for abortion coverage could have been available to 14.2 million reproductive-age women enrolled in Medicaid.[21] Of those Medicaid enrollees, 7.7 million were in states that do not use their own funds to cover abortions beyond Hyde's rare exceptions.[22] In practical terms, the Hyde Amendment forces many Medicaid and CHIP enrollees 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.[23]

The Hyde Amendment's Harms are Significant and Long-Lasting

The Hyde Amendment threatens people's lives

Abortion is an essential component of comprehensive health coverage. It is a common, safe, effective, and necessary reproductive health care service. One in four cisgender women in the United States will have an abortion by the age of forty-five.[24] Abortions are among the safest health care procedures in the United States.

Denying coverage for, and in effect, access to, abortion services exacerbates health inequities. If a person seeks abortion services and is denied access, they are at greater risk of experiencing severe and long-lasting negative health outcomes. People who give birth after being denied abortion access report more chronic pain and rate their overall health status as worse.[25] People who are denied abortion services experience more potentially life-threatening complications, such as preeclampsia and postpartum hemorrhage, than if they had received abortions.[26] The risk of death associated with carrying a pregnancy to term is, on average, about fourteen times higher than that with abortion.[27] 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 died from a condition that presents a higher risk of death among pregnant people.[28]

By denying abortion coverage, and in practice, access, the Hyde Amendment contributes to the United States' Black and Indigenous maternal mortality epidemic. BIPOC who are pregnant or postpartum face a disproportionate risk of pregnancy-related mortality compared to their white counterparts.[29] 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 per 100,000 births).[30]

The Hyde Amendment harms economic security

Economic instability and the inability to financially care for a child are leading reasons that many low-income pregnant people seek abortion services. About sixty percent of women seeking abortion services already parent at least one child.[31] Seventy-four percent of women seeking abortions state that having a child would interfere with their education, work, or ability to care for dependents. [32] Seventy-three percent indicate that they cannot afford to have a child.[33]

The Turnaway Study reaffirms that the reasons that people seek abortion services are valid and important. Those who seek but are unable to secure abortions are significantly more likely to experience long-term poverty than those able to obtain abortion services.[34] The Turnaway Study demonstrates that abortion access denials have 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.[35] 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.[36] In contrast, the economic impact of not being able to obtain abortions is compounded by the health risk of carrying a pregnancy to term in the United States.

Ensuring abortion access enables people to achieve goals related to education, employment, and a wanted change in residence.[37] 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.[38] Moreover, 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 receive abortions experience greater economic security and parental bonding than those born after abortions are denied.[39]

The EACH Act Would Restore and Create a Federal Right to Abortion Coverage

The EACH Act of 2021 would reverse the Hyde Amendment and related abortion coverage restrictions. It would restore or otherwise require coverage of abortion services for people who receive health coverage or care through enumerated federal programs and plans, including:

- People who are enrolled in Medicaid, Medicare, and CHIP;
- Indigenous people who receive their health care from IHS;
- Refugees who receive medical assistance through federal programs for domestic resettlement and assistance to refugees;
- People detained in federal prisons or detention centers, such as immigration detention;
- Young people in the care or custody of the United States' Department of Health and Human Services' Office of Refugee Resettlement;
- People who are enrolled in government-sponsored health insurance programs or plans due to a current or former employer relationship, including federal employees and their

dependents, Peace Corps volunteers; military members, veterans, and their dependents;
- People who receive other coverage, such as through a State health benefits risk pool; and
- People participating in other government-sponsored programs established after the EACH Act's date of enactment.

In addition to requiring that these federal health care programs and plans provide coverage, EACH would create a statutory right to that coverage. Beyond coverage, EACH would require that the federal government ensure access to abortion services for individuals eligible to receive health care in its own facilities or in facilities with which it contacts to provide medical care. This protection is crucial to ensure access for people in federal facilities such as prisons or detention centers.

The EACH Act also contains important provisions to promote equitable coverage of abortion services in the private health insurance market. It would prohibit the federal government from prohibiting, restricting, or otherwise inhibiting insurance coverage of abortion services by state or local governments or by private health plans, including those in the health insurance marketplaces established by the Patient Protection and Affordable Care Act (ACA). Furthermore, it would also repeal Section 1303 of the ACA, which unfairly segregates abortion services from other health coverage and imposes additional burdens on issuers of Qualified Health Plans covering abortion services.[40]

Conclusion

The United States should recognize and comply with international standards that affirm that access to abortion and maternal mortality prevention are human rights.[41] A myriad of reforms are needed to secure equitable access to abortion services for all. Decisively ending the Hyde Amendment and enacting the EACH Act of 2021 are crucial among them.

ENDNOTES

[1] For purposes of this issue brief, NHeLP defines "abortion services" holistically and consistent with the Equal Access to Act (EACH) Act of 2021 as "an abortion and any services related to and provided in conjunction with an abortion, whether or not provided at the same time or on the same day as the abortion."
[2] Laurie Sobel et al., *State Action to Limit Abortion Access During the COVID-19 Pandemic*, KFF (Aug. 10, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/state-action-to-limit-abortion-access-during-the-covid-19-pandemic/.
[3] The EACH Act of 2021 was introduced by Representatives Barbara Lee (D-CA), Ayanna Pressley (D-MA), Diana DeGette (D-CO), and Jan Schakowsky (D-IL) in the United States House of Representatives and by Senators Tammy Duckworth (D-IL), Patty Murray (D-WA), and Mazie Hirono (D-HI) in the United States Senate.
[4] Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2021, Pub. L. No. 116-260, §§ 506–507 (2020); Commerce, Justice, Science, and Related Agencies Appropriations Act, 2021, Pub. L. No. 116-260, §§ 202–203 (2020); Financial Services and General Government Appropriations Act, 2021, Pub. L. No. 116-260, §§ 613, 810 (2020).
[5] Congressional appropriators even go so far as to block Washington, DC from using its own funds to cover abortion services.
[6] *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; 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), https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304247.
[7] *See* Roberts et al., *supra* note 6 at 211.
[8] *Id.*
[9] *Id.*
[10] *Report on the Economic Well-Being of U.S. Households in 2018*, Board of Governors of the Federal Reserve System (May 2019), https://www.federalreserve.gov/publications/2019-economic-well-being-of-us-households-in-2018-dealing-with-unexpected-expenses.htm.
[11] 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.
[12] Abortion is a common, safe, effective, and necessary reproductive health care service. One in four cisgender women in the United States will have an abortion by the age of forty-five. *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 (last visited Dec. 3, 2020); Rachel Jones & Jenna Jerman,

Population Group Rates and Lifetime Incidence of Abortion: United States, 2008–2014, 107 *American Journal of Public Health* 1904–1909 (Nov. 2017), https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304042; *Fact Sheet: Induced Abortion in the United States*, GUTTMACHER INST. (Jan. 2018), https://www.guttmacher.org/fact-sheet/induced-abortion-united-states.

[13] *See* 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/; National Council on Disability, *Highlighting Disability / Poverty Connection, NCD Urges Congress to Alter Federal Policies that Disadvantage People with Disabilities* (Oct. 26, 2017), https://ncd.gov/newsroom/2017/disability-poverty-connection-2017-progress-report-release.

[14] *Poverty Status in the Last 12 Months*, U.S. CENSUS BUREAU, https://data.census.gov/cedsci/table?q=poverty&tid=ACSST1Y2019.S1701&hidePreview=true (last visited Dec. 6, 2020); *see* Badgett et al., *supra* note 13; *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 & REPRO. HEALTH 157, 161 (2017), https://pubmed.ncbi.nlm.nih.gov/28598550/; 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.

[15] *See Two Sides of the Same Coin: Integrating Economic & Reproductive Justice*, REPROD. HEALTH TECH. PROJ. (Aug. 2015), https://vawnet.org/material/two-sides-same-coin-integrating-economic-and-reproductive-justice; Jill E. Adams & Jessica Arons, *A Travesty of Justice: Revisiting Harris v. McRae*, 21 WM. & MARY J. WOMEN & L. 5 (2014).

[16] 123 CONG. REC. 19,700 (1977) (statement of Rep. Hyde).

[17] As of September 2020, Medicaid and CHIP covered nearly one in five (over seventy-seven million) people across fifty states and Washington D.C. *September 2020 Medicaid & CHIP Enrollment*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVICES, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html (last visited Dec. 3, 2020). As of June 2019, the programs covered an estimated 1,327,723 people across the five United States territories—American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the United States Virgin Islands. *Medicaid and CHIP in the Territories*, Medicaid and CHIP Payment and Access Commission 2 (Feb. 2021), https://www.macpac.gov/wp-content/uploads/2019/07/Medicaid-and-CHIP-in-the-Territories.pdf.

[18] NHeLP 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 issue brief and throughout our policy advocacy, education, and litigation, we use the words "woman" or "women" to conform with statutory or regulatory language or when needed to accurately reflect the scope of research that focuses solely on women. More inclusive statutory and regulatory language, as well as research, 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/.

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

[20] Consolidated Appropriations Act of 2021, Pub. L. No. 116-260, § 810 (2020).

[21] 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 18.

[22] *Id*.

[23] *See* Diana Greene Foster & M. Antonia Biggs, *Effects 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.

[24] *See* Rachel Jones & Jenna Jerman, *Population Group Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 *American Journal of Public Health* 1904–1909 (Nov. 2017), https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304042; *Fact Sheet: Induced Abortion in the United States*, GUTTMACHER INST. (Jan. 2018), https://www.guttmacher.org/fact-sheet/induced-abortion-united-states.

[25] 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 Gerdts 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/.

[26] *Id*.

[27] 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; 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).

[28] *Id*.

[29] *Id*.

[30] *Id*. More inclusive data collection is needed to illustrate the issue as it impacts LGBTQI-GNC individuals who experience pregnancy.

[31] 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.

[32] Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 PERSPECTIVES ON SEXUAL & REPRO. 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/PMC3729 671/.
[33] *Id.*
[34] *See* Foster et al., *supra* note 6 at 412.
[35] 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; Foster et al., *supra* note 6 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.
[36] 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.
[37] *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.
[3838] *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/.
[39] 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; *see* Foster et al., *supra* note 631 at 412.
[40] *See* Mara Youdelman et al., *National Health Law Program Comments Urge CMS to Reject Proposed Changes to Affordable Care Act*, NATIONAL HEALTH LAW PROGRAM (Jan. 9, 2019), https://healthlaw.org/resource/national-health-law-program-comments-urge-cms-to-reject-proposed-changes-to-affordable-care-act/.
[41] U.N., Int'l Covenant on Civ. & Pol. Rights, Human Rights Committee, Comm. on Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life, U.N. H.R.C. Doc. CCPR/C/GC/36 (2019), https://www.refworld.org/docid/5e5e75e04.html.