

**WHOSE  
CHOICE?  
HOW THE  
HYDE  
AMENDMENT  
HARMS  
POOR WOMEN**

**WHOSE  
CHOICE?**

**HOW THE  
HYDE  
AMENDMENT  
HARMS  
POOR WOMEN**

# TABLE OF CONTENTS

|                            |    |
|----------------------------|----|
| Foreword                   | 4  |
| Acknowledgments            | 7  |
| Glossary                   | 8  |
| Executive Summary          | 10 |
| Introduction               | 14 |
| How Hyde and Medicaid Work | 18 |
| Hyde's Impact              | 22 |
| Non-Discrimination States  | 36 |
| Human Rights Framework     | 42 |
| Conclusion                 | 45 |
| Recommendations            | 46 |

# FOREWORD

“Because of the Hyde Amendment, more than a million women have been denied the ability to make their own decisions about bringing a child into the world in the context of their own circumstances and those of their families.”

– Stephanie Poggi, *Executive Director of the National Network of Abortion Funds*

During last year’s healthcare reform debate, politicians of varying stripes made many claims about the Hyde Amendment. This is the 1976 measure that took away federal Medicaid coverage of abortion from women enrolled in the program. Congressional talk about the Hyde Amendment did little to shed light, however. Instead, the debate took place entirely in the abstract with no mention of Hyde’s impact on the life of a woman and her family. In the end, Congress and the Obama Administration moved not only to continue the Hyde Amendment, but also to extend its reach to millions of additional women.

**How does Hyde affect a woman, the family she is working to take care of, and her community?** This is the story that this new report from the Center for Reproductive Rights tells, documenting just how damaging this policy has been and promises to be.

Because of the Hyde Amendment, more than a million women have been denied the ability to make their own decisions about bringing a child into the world in the context of their own circumstances and those of their families. And many more women and families have been pushed into greater poverty as they struggle to find the money for an abortion.

At the center of this report are interviews with 15 women who describe exactly what this struggle means in their lives, for their families, and for the opportunity

to build a future. One woman tells us she has had to go without food for herself, her two sisters, and her two daughters in order to pay for an abortion. Another woman and her husband pawn virtually everything they own and still fall short of the amount they need. Another woman is forced to ask for money from someone she knows will judge her; because she requires help, she is denied the privacy afforded to women with greater resources. One woman describes her mounting panic as time passes and she can’t raise enough money; she worries she will be compelled to have a child she can’t care for. One woman barely sleeps, braiding hair around the clock to earn more money. Many women find that their hopes to continue school or move ahead at work are threatened.

But these stories are not only about the terrible costs to women and families—they are also testimony to women’s survival and bravery. They remind us that a woman will do everything she can to find a way—because the decision about whether and when to be a mother is so fundamental. In the face of posturing politicians and decades of efforts to shame, these women still believe in the inherent value of their lives and their families.

Thirty-four years after the Hyde Amendment passed, this is what it still boils down to—whether a woman in difficult financial circumstances can have a say in the shape of her own life and that of the family she’s

caring for. Do we accept the idea that a woman who lacks a high income simply loses her ability to decide if it's a good time to bring a child into the world? Do we accept a policy that denies this ability disproportionately to a woman of color? Because of racial inequities in the United States, women of color continue to be burdened by the Hyde Amendment in high numbers, making the policy also an issue of racial justice.

When Hyde was first implemented, many of us feared that deaths from illegal and self-induced abortions would skyrocket. While some women did die, the worst did not happen on a large scale, in part because women sacrificed other basic necessities in order to obtain an abortion, and in part because people across the country began organizing to support women and girls in their neighborhoods and communities. These activists joined together in 1993 to create the National Network of Abortion Funds. Today, the Network continues to honor the lives and hard-won futures of women and their families by directly helping them to pay for abortion care. Every year, we raise approximately \$3 million dollars and assist more than 21,000 women who would not otherwise be able to make their own best decision.

Our 102 member abortion Funds cannot, however, meet the enormous need created by the denial of federal Medicaid. In 2006, the Network joined with allies, including the Center for Reproductive Rights, to launch

the *Hyde: 30 Years Is Enough* campaign, a national effort to educate policymakers and allies and begin to move toward repeal of the Hyde Amendment.

Now, in 2010, as the economic downturn increases the need for abortion funding, as we prepare to face severe new restrictions on abortion access through healthcare reform, and as we face the reality of how little even pro-choice policymakers understand about the meaning of abortion in women's lives, the Network welcomes the Center's powerful new contribution to the movement for change. This report provides moving testimony and critical policy recommendations for all of us who believe in basic fairness. U.S. policy should not target and punish a woman and her family already struggling to survive. Instead, everyone should have the opportunity to build a life, be healthy, take care of our family, and contribute to the community we live in.

For too many in Washington, access to abortion continues to be an abstraction. But we know there is nothing abstract about the devastation caused by Hyde. **Human dignity, like healthcare, is meant to be—must be—for every one of us.**

## Stephanie Poggi

*Executive Director of the  
National Network of Abortion Funds*

# ACKNOWLEDGEMENTS

This report is a publication of the **Center for Reproductive Rights**. **Jinna Halperin**, consultant, conducted the interviews and research and drafted the report. **Cynthia Soohoo**, director of the U.S. Legal Program, conceptualized the project and supervised the research and drafting. **Karen Leiter**, human rights researcher, designed the investigation, contributed to supervising the project, and edited the report. **Jennifer Mondino**, staff attorney, contributed research and drafting and assisted with interviews. **Janet Crepps**, deputy director of the U.S. Legal Program, assisted with conceptualization, planning, and background interviews.

The Center partnered with the **National Network of Abortion Funds** to conceptualize and design the fact-finding, recruit women and staff from the Network's member Funds to be interviewed, conduct the interviews, and complete the report. The Center is indebted to **Stephanie Poggi**, executive director of the Network, for helping to conceptualize the report and for her invaluable contributions to all stages of the project. Special thanks also to other **Network staff** who assisted the fact-finding, including **D. Lynn Jackson**, national case manager; **Kim Nguyen**, administrative director/summit coordinator; and **Clara Hendricks**, program associate, for recruitment and assistance in the conduct of interviews. In addition, thanks to staff members at the following Network member abortion Funds for recruiting women to interview: the **Women's Medical Fund** in Philadelphia, Pennsylvania; the **Texas Equal Access Fund** in Dallas, Texas; the **Lilith Fund** in Austin, Texas; the **Chicago Abortion Fund**; and the **Atlanta Pro-Choice Action Committee**.

The fact-finding benefited greatly from the participation and support of **Elizabeth Barnes** of the **Philadelphia Women's Center**, **Nancy Boothe** of the **Feminist Women's Health Center**, **Renee Chelian** of **Northland Family Planning Centers**, **Amy Hagstrom Miller** and **Terry Sallas Merritt** of **Whole Woman's Health**, and **Robin Rothrock** of

**Hope Medical Group for Women**. We very kindly thank all of the staff at each of these clinics who assisted with recruiting women for interviews and otherwise gave their time and advice to the research, in particular **Andrea Ferrigno**, **Robin Gelberg**, **Mary Gulbernat**, **Stephanie Herold**, **Erin Keyes**, **Joanna Koch**, **Kathaleen Pittman**, and **Marva Sadler**. Special thanks as well to **Cristina Page**; **Destiny Lopez**, formerly of **ACCESS/Women's Health Rights Coalition**; and **Peg Johnston** of **The Abortion Care Network** for sharing their expertise in background interviews and to **Susan Berke Fogel** of the **National Health Law Program** for her expertise and review of sections of the report.

At the Center, special thanks to: President **Nancy Northup**, Director of Government Relations and Communications **Laura MacCleery**, and Legislative Policy Counsel **Sarah Lipton-Lubet** for reviewing the report; **Michelle Movahed**, staff attorney, and **Christina Zampas**, senior regional manager and legal adviser for Europe, for contributing to research; **Meredith Parrish Zingraff**, program associate, for contributing to research and fact-checking; **Genevieve Scott**, pro bono attorney, for contributing to research and assisting with citations; **Jean Bae**, volunteer attorney, for assisting with citations; and **Alice Chen**, legal assistant, for assisting with research logistics.

**Carveth Martin**, graphic designer and production manager, designed the cover and layout. **Bojana Stoparic**, staff writer, proofread and copyedited the report.

**Finally, the Center for Reproductive rights is grateful to the women seeking funding for abortion, clinic counselors, abortion Fund staff members, and providers who very generously shared their time and experiences by participating in the interviews at the heart of this report.**

# GLOSSARY

**Abortion Fund:** Abortion Funds, run in most cases by volunteers, provide financial assistance to low-income women who would otherwise be unable to obtain an abortion. Funds raise money from private individuals and foundations to help women cover the cost of abortions, and in many cases also provide other services, including travel and lodging assistance. The National Network of Abortion Funds includes 102 member groups in 40 states and several countries. Abortion Funds also conduct advocacy for public funding for abortion and comprehensive reproductive healthcare for all women.

**Beijing Declaration and Platform for Action:** The international consensus document adopted by nations participating in the 1995 United Nations Fourth World Conference on Women. The Platform for Action reaffirms the principle that women's rights are human rights and sets out the commitments of governments to the actions necessary to eliminate discrimination against women and promote women's human rights, including reproductive rights.

**Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)** (adopted by the UN General Assembly in 1979): A comprehensive international treaty often described as an international bill of rights for women. It defines what constitutes discrimination against women and sets forth a national action plan for ensuring women's equality—a framework for government policy to combat gender inequality. State parties' compliance with CEDAW is monitored by the Committee on the Elimination of Discrimination against Women (CEDAW Committee). The United States has signed, but not ratified, CEDAW.

**Convention on the Elimination of All Forms of Racial Discrimination (CERD)** (adopted by

the UN General Assembly in 1965): The international treaty that protects all individuals from discrimination based on race, color, descent, and national or ethnic origin. Both policies and practices that are by intent discriminatory and those with a discriminatory impact are prohibited. State parties' compliance with CERD is monitored by the Committee on the Elimination of Racial Discrimination (CERD Committee). The United States has ratified CERD.

**Harris v. McRae (1980):** The U.S. Supreme Court case that upheld the Hyde Amendment, prohibiting federal Medicaid funding for medically necessary abortions, except in cases of rape, incest, or life endangerment. The Court also held that states are not required to fund abortions under their state Medicaid programs for which federal funds are unavailable.

**Hyde Amendment:** First enacted in 1976, this amendment currently prohibits federal funding for abortion under the Medicaid program, except in cases of rape, incest, or life endangerment. If states wish to fund abortion beyond these narrow exceptions, they must pay the entire cost with state funds.

**Hyde State:** A state in which coverage for abortion under the state's program of medical care and health-related services for poor and low-income individuals is available only in cases of rape, incest, or life endangerment, in line with the restrictions imposed on federal funds by the Hyde Amendment. There are 26 Hyde states.

**Hyde-Plus State:** A state that has slightly expanded coverage of medical care and health-related services for poor and low-income individuals, including abortions in cases of fetal abnormality or endangerment of a pregnant woman's physical health. There are six Hyde-plus states: Indiana, Iowa, Mississippi, South Carolina, Utah, and Wisconsin.

**International Covenant on Civil and Political Rights (ICCPR)** (adopted by the UN General Assembly in 1966): An international treaty protecting individuals' civil and political human rights, such as the right to vote and the right to freedom of expression. State parties' compliance with the ICCPR is monitored by the Human Rights Committee. The United States has ratified the ICCPR.

**Medicaid:** Under the federal Medicaid program, federal and state governments jointly pay for healthcare services for eligible poor and low-income individuals. Medicaid is the largest source of funding for medical and health-related services for low-income and indigent people in the United States, though not all poor people qualify for Medicaid. Some states have state programs that provide healthcare coverage for poor and low-income individuals using state funds that are more generous than federal Medicaid in terms of covered services or populations (referred to in this report as "state Medicaid").

**Medication Abortion:** In medication, or medical, abortions, a drug or a combination of drugs is used to induce abortion. Medication abortions may be obtained during the first seven to nine weeks of pregnancy.

**Non-Discrimination State:** A state that has elected to use its own funds to pay for abortions in its program of medical care and health-related services for poor and low-income individuals beyond the restrictions of the Hyde Amendment, treating abortion the same way as any other healthcare service. There are 17 non-discrimination states. Four of these voluntarily fund abortion. In the thirteen others, state courts have refused to follow *Harris v. McRae*, finding instead that restrictions on public funding for abortion violate women's fundamental rights as guaranteed by state laws and constitutions.

**Presumptive Eligibility:** States may create presumptive eligibility programs under Medicaid for pregnant women wherein the application and enrollment process is streamlined and expedited so that women are able to immediately receive temporary healthcare coverage.

**Reproductive Rights:** Reproductive rights embrace the rights to health, life, equality, information, education, privacy, freedom from discrimination, freedom from violence, and self-determination, including the decision regarding when and whether to bear children. These fundamental rights are found in national laws as well as human rights treaties and consensus documents.

# EXECUTIVE SUMMARY

“After 34 years, **repealing the Hyde Amendment** offers the United States a **critical opportunity to restore women’s equality** by making a genuine commitment to reproductive health for all women, **regardless of economic status.**”

Abortion is a constitutional right. Existing federal and state laws, however, dramatically restrict women’s access to abortion. These laws, including mandatory waiting periods and biased counseling requirements, have negative consequences on a woman’s ability to obtain an abortion, both by erecting hurdles to accessing an abortion and by making it more difficult for doctors to continue to provide services. For poor women, lack of public funding for abortion is one of the most severe barriers to access. Low-income women scramble to obtain funding, often delaying their procedures by days or weeks, or carry their pregnancies to term after failing to raise the needed funds. Beyond the stigma and shame that women may face when deciding to have an abortion, the financial toll and medical complexity of the procedure increase practically daily as women make the necessary logistical arrangements to locate a provider and procure funding. As each day passes, the costs become increasingly unaffordable and the procedure more unattainable. Women struggling to put together the money for an abortion find that, in a matter of weeks, they are forced to undergo a more involved, more expensive, and less widely available second-trimester abortion.

This report exposes the harms perpetrated by the Hyde Amendment—the law that prohibits federal Medicaid dollars from paying for abortion services except in the most extreme circumstances. The interviews with women, abortion clinic counselors, and abortion

Fund staff described in this report offer insight into the struggles that low-income women endure to pay for their abortions, often forgoing basic necessities for themselves and their families and risking their health. In making a case for repeal, this report also discusses the successes and challenges of a few states that allow state funds to cover abortion. The U.S. government has a responsibility to respect and ensure each person’s right to autonomy, particularly the right to make fundamental decisions about childbearing and family, and to access medical services necessary to lead a healthy life. The stories told in this report demonstrate that the government is abdicating its responsibility to poor women by failing to repeal the Hyde Amendment.

## FEDERAL AND STATE MEDICAID PROGRAMS AND THE HYDE AMENDMENT

Medicaid is the largest source of funding for medical and health-related services for low-income and indigent people in the United States.<sup>1</sup> Medicaid plays a particularly important role in providing women’s health coverage, especially for women of reproductive age. One in ten American women receives Medicaid, and women comprise more than two-thirds of adult enrollees.<sup>2</sup> The Hyde Amendment, named after a 1976 rider to the Appropriations Act sponsored by Representative Henry Hyde (R-IL), eliminated federal funding for abortion except where necessary to save a woman’s life. The current version of the amendment prohibits the use of federal Medicaid funds for abortion except

in cases of rape, incest, or endangerment of the life of the pregnant woman.<sup>3</sup> Even for women who meet the eligibility criteria imposed by Hyde, receiving Medicaid coverage for abortion in practice is immensely challenging, if not impossible.

States may use their own funds to cover abortion outside of Hyde's restrictive limitations. As of 2010, only 17 states have rejected Hyde, using state funds to ensure women's reproductive health and autonomy.

In states where state funding programs ("state Medicaid") pay for abortion to the same extent as other medical care, referred to in this report as non-discrimination states, the state plays a fundamental role in ensuring that low-income women are able to obtain abortion care. Many challenges remain, however. While some state programs work well and provide sufficient reimbursement to providers, in other states providers often struggle to recoup the costs of treating women enrolled in Medicaid due to low reimbursement rates, long delays in receiving payment and, in some states, a claim submission process that is unique to abortion services. Other barriers to abortion care in these states include the reality that many providers do not accept Medicaid, making it difficult for poor women to find a provider. In addition, narrow Medicaid eligibility rules that exclude many women in need, including immigrants in most states, mean that many low-income women in the non-discrimination states must still turn to abortion Funds for assistance.

## HUMAN RIGHTS AND THE HYDE AMENDMENT

Reproductive rights include a woman's right to make fundamental decisions about her life and family, to access the reproductive health services necessary to protect her health, and to decide whether and when to have children. By restricting access to abortion, the Hyde Amendment violates these fundamental human rights for poor and low-income women in the United States. The funding restrictions discriminate against women by singling out and excluding from Medicaid coverage, except in the most extreme circumstances,

a medical procedure that only women need. The Hyde restrictions make it extremely difficult for poor and low-income women to finance abortion services and severely limit their right to reproductive healthcare. Hyde also discriminates against poor and low-income women and women of color by disproportionately undermining their reproductive health choices.

## THE IMPACT OF FUNDING RESTRICTIONS

Medicaid funding restrictions for abortion force women to continue unwanted pregnancies, cause them to delay receiving abortions, and impose additional financial strains on low-income and indigent women. Financing an abortion is the most reported obstacle to obtaining one, often forcing women to delay their abortion until well into the second trimester, at which point it is both a more involved procedure and a significantly more costly one. Aside from causing delays, paying for an abortion imposes financial strain on Medicaid-eligible women, who report forgoing basic necessities, borrowing money, or selling or pawning personal and household items. Women who are unable to obtain funding are forced to continue their unwanted pregnancies. The economic downturn has also influenced the impact that funding restrictions have on poor women by increasing demand for abortion and the need for financial assistance to cover the procedure. In 2008, 42% of women obtaining abortions lived below the federal poverty level, an increase of almost 60% from 2000.<sup>4</sup>

## PUBLIC FUNDING FOR ABORTION

The accessibility of public funding for abortion varies widely across states, not only because of the variation in states' policies regarding whether to fund abortion in line with the Hyde Amendment or more expansively, but also because of differences in how state Medicaid programs operate and process applications for Medicaid funds. These differences mean that it can be far more difficult for a woman in one state to secure funding for abortion, and thus to exercise her right to access a safe and legal abortion, than it might be for a similarly situated woman in a neighboring state.

## RESPECT FOR THE REPRODUCTIVE HEALTH AND AUTONOMY OF ALL WOMEN REGARDLESS OF ECONOMIC STATUS

As demonstrated by the findings in this report, poor and low-income women are harmed, some grievously, by the Hyde Amendment's discriminatory restrictions prohibiting Medicaid funding for abortion. By restricting these women's access to abortion, the law violates their fundamental human rights and denies them their reproductive autonomy. Free from these restrictions, women throughout the country would be empowered to make their own decisions regarding what is best for themselves and their families. After 34 years, repealing the Hyde Amendment offers the United States a critical opportunity to restore women's equality by making a genuine commitment to reproductive health for all women, regardless of economic status.

### RECOMMENDATIONS

For nearly three and a half decades, poor and low-income women in the United States have been the victims of political discrimination waged against their reproductive autonomy.<sup>5</sup> The U.S. government, state governments, the United Nations, national organizations representing the medical community, reproductive healthcare providers, and advocacy organizations need to take urgent action to repeal the Hyde Amendment and permit the use of federal and state Medicaid funds for abortion.

- The federal government should repeal the Hyde Amendment and other restrictions that prohibit federal funding of abortion.
- State governments should ensure that, where restrictive state laws currently require that abortions be covered by Medicaid in certain circumstances, funding is available to the same extent that state funds are available for other medical procedures.
- In states that recognize an obligation to fund abortions beyond the limited instances provided for under the Hyde Amendment, state governments

should take concrete steps to improve procedures for processing Medicaid claims for abortion to ensure that providers are able to obtain reimbursement for covered procedures.

- The United Nations' human rights bodies and special rapporteurs should speak out against restrictions on public funding for reproductive health services as fundamental human rights violations.
- Reproductive healthcare providers should educate patients about their right to access Medicaid-funded healthcare, and, if possible, become approved Medicaid providers and submit claims to state Medicaid offices for reimbursement for all reproductive healthcare services covered in their state.
- National organizations representing the medical community should adopt resolutions and guidelines supporting the inclusion of reproductive healthcare, including abortion, as an integral part of a comprehensive U.S. healthcare program.
- Advocacy organizations and members of the public should advocate for the repeal of the Hyde Amendment and federal and state laws that impose restrictions on public funding for abortion and other reproductive health services.

# INTRODUCTION

“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.”

– Statement from Representative Henry Hyde (R-IL) during a floor debate in 1976 <sup>6</sup>

Abortion is a constitutional right in the United States. Existing federal and state laws, however, dramatically restrict women’s access to abortion. These laws, including mandatory waiting periods and biased counseling requirements, have negative consequences on women’s ability to obtain an abortion. One of the laws that has had a profound impact on women’s access is the Hyde Amendment, which since 1976 has barred federal Medicaid coverage of abortion, except in the most extreme circumstances.

Although the incidence of abortion in the United States has steadily declined since 2000,<sup>7</sup> abortion remains one of the most common medical procedures. One in three women has an abortion in her lifetime.<sup>8</sup> Unsafe abortions are largely an issue of the past, and abortion is considered one of the safest medical procedures. Sixty-one percent of women having abortions are mothers with one or more children.<sup>9</sup> In 2008, 69% of women obtaining abortions were either poor or low-income.<sup>10</sup> Despite the fact that abortion is a common medical procedure, women’s access to this essential healthcare service is relegated to the domain of politics, rather than being a personal decision. This is particularly pronounced in the abortion funding context.

While women with means face numerous obstacles in obtaining abortions, they typically retain the right to access an abortion in a safe and timely manner, either by paying out of pocket or through private health insurance. By contrast, because of the Hyde Amendment

and corresponding state bans on Medicaid funding for abortion, poor and low-income women are forced to scramble to obtain funding, often delaying their abortions by days or weeks while they sort out financing. In the worst cases, they are forced to carry their pregnancies to term after failing to raise the necessary funds. These women, because they are poor and depend on the government for their healthcare, are most easily targeted by a government policy that has as its goal the prevention of all abortions. And the policy has succeeded in undermining women’s reproductive decision-making. According to studies looking at the impact of the Hyde Amendment, 18–37 % of women who would have obtained an abortion if Medicaid funding were available continue their pregnancies to term.<sup>11</sup>

Even for low-income women who ultimately are able to obtain abortions, forcing poor women to self-finance an abortion poses a substantial challenge that has short- and medium-term implications for their family’s financial health, as well as their capacity to meet daily household needs.

**Consider the story of financial hardship told by W.S., a woman unable to receive Medicaid coverage for her abortion, who was interviewed for this report. She and her husband had to borrow money, pawn numerous possessions, obtain help from an abortion Fund, and take out a loan to cover the cost of her abortion.** As a result, she was left with debt and little money for necessities. **W.S.** is a 29-year-old mother of six who

reported receiving food stamps and being on public assistance that provides free medical care at one local clinic; her children are on Medicaid.<sup>12</sup> She discovered that she was pregnant shortly after her husband was laid off from his job. She was 15 weeks pregnant when she decided to have an abortion. Neither partner wanted to do so, but they knew they could not afford another child. She had been preparing to tell her family about the pregnancy when they made the decision to terminate; they did not tell anyone, knowing that her family disapproved. She initially planned to go to one clinic where she paid \$80 for an ultrasound before realizing she had to go elsewhere because the first clinic did not accept financial assistance from an outside source. The next clinic quoted her a price of \$1696. When she went, she was told that she would be charged an extra \$250 because her weight complicated the procedure, plus \$100 for another ultrasound, making the total cost over \$2,000. She received some funding assistance from the Network's National Reproductive Justice Fund, used \$395 from her paycheck, and borrowed money from her brother to have an abortion at 17 weeks. "I needed \$500-something dollars and I had to lie to my brother ... I told him I was getting the clamp in my uterus that keeps me from being pregnant removed." On top of that, both she and her husband took out a short-term loan for \$50 each. Still short, they were forced to pawn her wedding ring and a number of personal items, including the vacuum cleaner, the carpet cleaner, two drills, tools, and the computer. She now pays approximately \$70 per month to have the pawn shop hold these items. Following her abortion, she received a prescription, but she could not afford to fill it. "I couldn't afford to buy the pills.... They were \$21, and I never bought them."

In addition to the initial financial burden imposed on women, the financial toll and medical complexity of abortion increases practically daily as women struggle to make the necessary logistical arrangements to locate a provider and procure the needed funding. When it comes to abortion, earlier is preferable. Abortions cost less earlier in pregnancy.<sup>13</sup> In addition, more provid-

ers offer first-trimester abortions,<sup>14</sup> and while abortion is one of the safest medical procedures, first-trimester abortions, whether medical or surgical, are safer, shorter, and easier.<sup>15</sup> Because of the Hyde Amendment, however, low-income and indigent women are routinely forced to delay their abortions. On average it takes them two to three weeks longer than other women to obtain one,<sup>16</sup> forcing them to endure more complicated and lengthier later procedures and shoulder significant additional costs.

The Hyde Amendment undermines the goals of the very the program that it restricts. Medicaid was created in order to ensure the provision of necessary healthcare to those too poor to afford it.<sup>17</sup> In providing Medicaid to indigent and low-income individuals, the government recognized that medical care is essential for all persons, yet at the same time is often out of reach of the poorest, whose health is often negatively affected by poverty and lack of access to medical care. Because of the Hyde Amendment, however, Medicaid can cover all medically necessary services except one—abortion. This restriction is neither based in medical evidence nor budgetary considerations; it is merely, and egregiously, political. Because of the ideology of some, poor women are unable to obtain otherwise available federal funding for a single, commonly needed, and often prohibitively expensive medically necessary healthcare service.

## SCOPE OF THE INVESTIGATION AND METHODS

From October 2009 through February 2010, researchers from the **Center for Reproductive Rights (the Center)** and the **National Network of Abortion Funds (the Network)** together conducted 27 interviews for this report. In conducting this research, the **Center** and the **Network** sought to collect a broad range of stories highlighting how poor women are adversely affected by the funding restrictions imposed by the Hyde Amendment. These stories are meant to be illustrative of Hyde's impact.

Among those interviewed were 15 women from various regions of the United States whose lives have been affected by the Hyde Amendment.<sup>18</sup> Criteria for participation in the investigation included residence in the District of Columbia or one of the 26 states that do not provide state Medicaid funding for abortion beyond the few exceptions permitted under the Hyde Amendment,<sup>19</sup> being age 18 or over, being eligible for Medicaid (whether or not receiving it),<sup>20</sup> and having sought financial assistance to pay for an abortion within the previous 12 months.

To recruit women, the **Center** collaborated with independent abortion providers who operate clinics in four locations in Texas; Philadelphia, Pennsylvania; Detroit, Michigan; Atlanta, Georgia; and Shreveport, Louisiana.<sup>21,22</sup> In addition, the Network recruited women by issuing a call to its national case manager and member Funds. Funds in Pennsylvania, Texas, Illinois, Georgia, Oregon, and Washington offered referrals, along with the Network's national case manager.

The **Center** and the **Network** also interviewed one staff member at each of the collaborating clinics who counsels and supports women in obtaining abortions and, when needed, helps them to secure financial assistance. In addition, we interviewed representatives of three of the Network's member Funds,<sup>23</sup> who offered additional insight into the challenges that women face financing their abortions. **(See Box: Abortion Funds: Providing Critical Support to Women in Need.)**

Finally, researchers interviewed three providers—from Maryland, Washington, and West Virginia—to discuss the reimbursement process for abortion services in non-discrimination states, where state Medicaid coverage for abortion goes beyond the parameters of Hyde.<sup>30</sup> These interviews highlighted some of the challenges and obstacles to providing abortions in states that cover abortion with their own funds.

Researchers conducted semi-structured phone interviews, which lasted approximately 45 minutes.

All interviews were anonymous, unless participants explicitly expressed a willingness to use their name. Verbal informed consent was obtained from participants before the interviews.<sup>31</sup>

# ABORTION FUNDS: PROVIDING CRITICAL SUPPORT TO WOMEN IN NEED

“**L.B. is a 30-year-old woman with a school-aged daughter. In December 2008, she was laid off from her job at a medical office.** Since then, unable to find another job, she enrolled in the Supplemental Nutrition Assistance Program [food stamps] and is spending down her savings account to pay her rent and other living expenses. **L.B.** had been using a hormonal contraceptive, so she was surprised to find herself pregnant. She borrowed from her uncle toward the cost of her abortion. [The Women’s Medical Fund] provided \$100 to fill the remaining gap.”

— An account shared by the executive director of the Women’s Medical Fund<sup>24</sup>

In response to the lack of public funding for abortion, the 100-plus member groups of the **National Network of Abortion Funds** raise money to help thousands of poor women cover the cost of their abortions<sup>25</sup> and, in many cases, provide supplemental services. Most abortion Funds are run by volunteers and raise money from private individuals and foundations to provide grants to women needing financial assistance.<sup>26</sup> Aside from helping women cover the cost of abortion care, many abortion Funds also help women pay for emergency contraception, offer women additional information, and provide support services such as

transportation to a clinic, housing for women traveling long distances, meals, gas money, child-care during the procedure, and assistance obtaining medications. Some Funds also advocate on behalf of women with individual clinics or, in states where Medicaid pays for most abortions, help women to enroll in Medicaid and provide information on how to obtain social services.<sup>27</sup> **Abortion Funds in the Network** also conduct advocacy for expanded public funding of abortion.<sup>28</sup> In addition to the Network, organizations such as **Planned Parenthood and the National Abortion Federation** help low-income women pay for abortion services.<sup>29</sup>

# HOW HYDE AND MEDICAID WORK

“The Hyde Amendment’s denial of public funds for medically necessary abortions plainly intrudes upon [women’s] constitutionally protected decision, for both by design and effect it serves to coerce indigent pregnant women to bear children that they would otherwise elect not to have.”

– Justice Brennan, dissenting in *Harris v. McRae*, the Supreme Court decision finding the Hyde Amendment constitutional<sup>32</sup>

Under the federal Medicaid program,<sup>33</sup> federal and state governments jointly pay for healthcare services for eligible poor and low-income individuals and their families.<sup>34</sup> Medicaid is the largest source of funding for medical and health-related services for low-income and indigent people in the United States.<sup>35</sup> It currently provides health and long-term care services to 60 million individuals, including children and parents, persons with disabilities, and seniors.<sup>36</sup> Medicaid plays a particularly important role for women, and especially women of reproductive age. One in ten women in the United States is covered by Medicaid, and women make up more than two-thirds of adult Medicaid beneficiaries.<sup>37</sup> Thirty-seven percent of women of reproductive age in families with incomes below the federal poverty level rely on Medicaid for healthcare coverage.<sup>38</sup> According to a 2009 Kaiser Family Foundation report, “Medicaid pays for more than four in ten births nationwide, and in several states, covers more than half of total births.”<sup>39</sup>

States have the option of whether they want to participate in the federal Medicaid program, and if they do so, they agree to abide by certain program rules. All states have agreed to participate. Eligibility for a state Medicaid program is based on a complicated set of rules and varies tremendously across the country.<sup>40</sup> Coverage is limited to only the poorest households,

and yet not all people who are poor qualify for Medicaid. **(See Box: The Case of Immigrant Women.)**

The recently enacted healthcare reform legislation will expand Medicaid eligibility to all non-elderly adults living at or below 133% of the federal poverty level (FPL), thereby providing a safety net for millions of Americans who would otherwise be priced out of the insurance marketplace.<sup>41</sup>

Federal law allows states to set more favorable eligibility requirements for pregnant women, and the majority of states have done so. This enables some women who would not normally qualify for Medicaid based on their incomes to receive Medicaid once they become pregnant. For pregnant women, state income eligibility requirements for Medicaid coverage range from 133% to 300% of the federal poverty level; most states cover pregnant women between 133% and 185% of FPL<sup>46</sup>—\$24,352 to \$33,874 for a family of three in 2009/2010.<sup>47</sup> Among 44 states responding to a state survey on Medicaid coverage for perinatal services, 38 reported extending eligibility to pregnant women beyond the minimum requirements.<sup>48</sup> Twenty-six states reported offering pregnant women presumptive eligibility, which allows providers “to grant immediate, temporary Medicaid coverage to women who meet certain criteria while formal eligibility determination is

being made.”<sup>49</sup> The vast majority of states surveyed also reported using a variety of methods to streamline the application process for eligible women in order to facilitate their enrollment.

In 1976, Representative Henry Hyde (R-IL) sponsored a rider to the annual Appropriations Act that prohibited federal funding for abortion except where necessary to save the pregnant woman’s life. Now known as the Hyde Amendment, the rider, in various forms, has been attached to every Appropriations Act since then.<sup>50</sup> Under the current version of the Hyde Amendment, federal Medicaid funds may only be used for abortions in cases of rape, incest, or endangerment of the life of the pregnant woman.<sup>51</sup> States are required to provide matching funding for cases that fall within these narrow exceptions. If states choose to provide additional coverage for abortion, they must shoulder the entire cost.

In 1980, the U.S. Supreme Court held that the Hyde Amendment did not violate the federal constitution.<sup>52</sup> Recognizing that the Hyde Amendment undermines poor women’s constitutional right to abortion, four justices dissented from the decision. “[T]he Hyde Amend-

ment,” wrote Justice William Brennan, “is nothing less than an attempt by Congress to circumvent the dictates of the Constitution and achieve indirectly what *Roe v. Wade* said it could not do directly.”<sup>53</sup> The dissenting justices would have found the Hyde Amendment unlawful because women were being deprived of “a government benefit for which they are otherwise eligible, solely because they have attempted to exercise a constitutional right.” Also of concern to the justices was the fact that Hyde specifically targets the constitutional rights of poor women. The Hyde Amendment, wrote Justice Thurgood Marshall, “is designed to deprive poor and minority women of the constitutional right to choose abortion.”<sup>54</sup> **(See Box: International Perspectives on Public Funding for Abortion.)**

As of 2010, 26 states prohibit the use of their state Medicaid funds for abortion except in the limited cases permitted by Hyde.<sup>64</sup> South Dakota, in violation of federal Medicaid law, pays for abortions only in cases of life endangerment. Six states, referred to in this report as Hyde-plus states, have slightly expanded on the Hyde Amendment’s funding restrictions, with two adding fetal abnormalities and four including endan-

## THE CASE OF IMMIGRANT WOMEN

Immigrant women are among those with restricted access and limited eligibility for Medicaid. Before 1996, legal immigrants were subject to the same eligibility guidelines as U.S. citizens.<sup>42</sup> **The Personal Responsibility and Work Opportunity Act of 1996**, otherwise known as welfare reform, required that almost all new legal immigrants wait five years before applying for Medicaid benefits, limiting coverage to only emergency situations (including childbirth).<sup>43</sup> It also permitted states to permanently deny Medicaid benefits to non-citizens.<sup>44</sup>

Such measures to restrict poor immigrant women’s access to healthcare services, including abortion, pose substantial threats to their reproductive health and autonomy. Some states provide Medicaid and/or State Children’s Health Insurance Program (SCHIP) coverage for pregnant women during the five-year waiting period.<sup>45</sup> Significantly, recently enacted healthcare reform legislation has failed to remedy the denial of access to comprehensive healthcare services for poor and low-income immigrant women.

# INTERNATIONAL PERSPECTIVES ON PUBLIC FUNDING FOR ABORTION

The U.S. policy of denying public funds for abortion is even more striking when compared to the abortion policies of other developed nations.

Twenty-one of the twenty-seven members of the European Union,<sup>55</sup> an additional five European nations and Israel<sup>56</sup> provide funding for abortions through public health insurance or in public health facilities. In **Canada**, all provinces provide abortion coverage at hospitals and many also cover costs at private abortion clinics.<sup>57</sup> Given the fundamental rights implicated by women's access to abortion, a Canadian court found that abortion funding procedures that do not enable women to access abortions in a timely way violate the Canadian Charter of Rights and Freedom—Canada's "Bill of Rights."<sup>58</sup> The court held that a provincial health program limiting funding to public hospitals where women were subject to long delays and that excluded services provided by abortion clinics violated women's right to liberty and security of the person, freedom of conscience, and equality.

Outside of Europe, Canada, and Israel, several other countries consider the provision of public

funding to be an inseparable element of the right to abortion, including South Africa, Mexico City, and Nepal. When **Mexico City** voted to legalize abortion in April 2007,<sup>59</sup> a core element of the legislation was making abortion both available and accessible to women, including women who could not afford to pay for the procedure.<sup>60</sup> The Supreme Court of **Nepal** also recognized that ensuring that abortion is financially accessible is a necessary component of the legal guarantee of safe and affordable abortion. Following a successful lawsuit brought by the Center to legalize abortion, the Supreme Court ordered the government to establish an abortion fund to ensure that abortions were accessible to poor and rural women.<sup>61</sup> The Court's ruling provides that the abortion fund must include sufficient resources to fund abortions and to educate the public and health service providers on the existing abortion law.<sup>62</sup>

**South Africa** adopted a similar view when it legalized abortion. The Choice on Termination of Pregnancy Act, passed in 1997, both established women's right to abortion during the first trimester and ensured access by providing abortions free of charge at designated public hospitals and clinics.<sup>63</sup>

germent of the pregnant woman's physical health. Seventeen non-discrimination states use their own Medicaid funds to pay for all or most medically necessary abortions; four states do so voluntarily, while the remaining 13 do so pursuant to a court order.<sup>65</sup> Interpreting state constitutional law, courts in these states have recognized that the fundamental privacy right implicated in the decision of whether or not to have an abortion requires government neutrality<sup>66</sup>

and that selectively denying benefits to women exercising a fundamental right violates equal protection.<sup>67</sup> **(See Table: State Funding for Abortion under Medicaid.)**

## STATE FUNDING FOR ABORTION UNDER MEDICAID <sup>68</sup>

| BREAKDOWN OF STATE FUNDING REGULATIONS  | STATES   | TOTAL                            |
|---|--|----------------------------------|
| <p><b>Hyde States:</b></p> <p>Life endangerment, rape, and incest</p>   | Alabama, Arkansas, Colorado, Delaware, Florida, Georgia, Idaho, Kansas, Kentucky, Louisiana, Maine, Michigan, Missouri, Nebraska, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia, Wyoming | <b>26</b>                        |
| <p><b>Hyde-Plus States:</b></p> <p>Life endangerment, rape, incest, and fetal abnormality</p> <p>Life endangerment, rape, incest, and endangerment of physical health</p> | <p>Iowa, Mississippi</p> <p>Indiana, South Carolina, Utah, Wisconsin</p>   | <p><b>2</b></p> <p><b>4</b></p>  |
| <p><b>Non-Discrimination States:*</b></p> <p>Medical necessity</p>  | <p>Pursuant to court order: Alaska, Arizona, California, Connecticut, Illinois, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, Oregon, Vermont, West Virginia</p> <p>Voluntarily: Hawaii, Maryland, New York, Washington</p>                               | <p><b>13</b></p> <p><b>4</b></p> |
| Life Endangerment Only  | South Dakota   | <b>1</b>                         |

\*As of August 1, 2010, the District of Columbia provides funding for all medically necessary abortions.

# HYDE'S IMPACT

“There is some sort of assumption out there that women who choose abortion have not yet had a family, not yet gotten married, not yet started their careers. The majority of women who show up for abortion are already mothers, are between the ages of 20 and 24, are already sexually active and have been using birth control... These women are our sisters, our mothers, our rulers, our leaders, our teachers, our principals, our rock stars, our political people, they're everywhere...”

— Vice President of Whole Woman's Health<sup>69</sup>

The Hyde Amendment's restrictions affect low-income women in three principal ways: by causing them to delay procedures, by imposing additional financial strain on their already difficult economic situations and by forcing them to continue unwanted pregnancies. As of 2006, the average amount women paid for a first-trimester abortion was \$413; at 20 weeks, the cost of an abortion was roughly three times as much.<sup>70</sup> The costs continue to rise and vary widely, influenced in part by how far along the pregnancy is, as well as by location and availability of providers. One woman interviewed reported paying over \$600 for her abortion performed at 16 weeks, while another woman reported paying over \$2,000 for an abortion at 17 weeks, and another was charged \$1,510 for an abortion at 20 weeks.

Asked to describe some of the circumstances of the women whom they assist with paying for abortions, clinic counselors reported that many women have one or more children and are single, in school, working low-paying jobs or trying to enter the workforce, not receiving help from their children's father, and working to make ends meet.<sup>71</sup> One counselor reported that

75% or more of her clinic's clients seeking funding assistance are enrolled in Medicaid and their stories include recent job loss, low-income jobs, and more than one child at home with no support from partners.<sup>72</sup> Another said that “the majority [of women] were on birth control, but maintaining birth control was not easily accessible for them—either their prescription ran out or they couldn't afford to get it renewed.”<sup>73</sup> Another counselor reported speaking with women who say “I need an abortion, because I can't afford another baby. I'm a single mom. I just got back to school, and I can't afford to drop out of school right now. I just got the baby out of Pampers and to have another would cause too many setbacks.”<sup>74</sup>

The Women's Medical Fund Director stated that many of the women the Fund serves are in precarious living situations. “A lot of women we talk to are virtually homeless. They're not on the street and not in shelters, but they live short-term with family, with friends, with anybody who's willing to take them and their kids in for six months or three months or any amount of time.”<sup>75</sup>

**(See Box: Profiles of Women Interviewed for this Report.)**

Asked to discuss her thoughts on the typical barriers that poor women face when seeking an abortion, the Women's Medical Fund Director reported that "money is the main one."<sup>76</sup> She went on to say that financial barriers to abortion are not limited to women who receive Medicaid. "About a third of the women we help aren't enrolled in Medicaid. Most are ineligible

[for non-pregnancy related Medicaid]. So it's partly the Hyde Amendment, but also the general problem with people being under-insured or uninsured. There are people who aren't poor enough for Medicaid. It's all the lack of a safety net for people, or an inadequate safety net."<sup>77</sup>

## PROFILES OF WOMEN INTERVIEWED FOR THIS REPORT

### DEMOGRAPHICS

- **Eight** of the women were Black/African-American, **two** were White/Caucasian, **two** were Hispanic, **one** was African-American and Caucasian, **one** was Caucasian and Indian-American, and **one** was African- and Cuban-American.
- **Twelve** had one or more children.
- **Three** reported being in an abusive relationship leading to their unwanted pregnancy.

### WORK AND SCHOOL

- **Eight were in school full-time** and either working (4), looking for work (2), about to start a job (1), or recently laid off (1).
- **Four worked full-time** and were in school full- or part-time.
- **Seven worked part-time**, one of whom had several part-time jobs.
- **One was looking for work.**

### ENROLLMENT IN PUBLIC ASSISTANCE PROGRAMS OR SOURCES OF OTHER FINANCIAL SUPPORT

- Eight received food stamps; another said that it was not worth missing work to collect them because they amounted to so little.

- Three of the eight enrolled in the food stamp program following their abortions.
- A tenth sought her sister's assistance to help the family obtain sufficient food.
- Four reported enrollment in public assistance.
- One was enrolled in disability insurance.
- Two obtained child support.

### ABILITY TO OBTAIN MEDICAID AND HEALTH INSURANCE

- Seven were enrolled in Medicaid at the time of the abortion.
  - Three of these only met income eligibility standards for Medicaid coverage while pregnant.
- One had student health insurance.
- Seven had no insurance at the time of the abortion.
  - One of these enrolled in Medicaid following her abortion.
  - Another had children enrolled in Medicaid.
  - A third was enrolled in Medicaid during a prior pregnancy.

Financing an abortion is among the most common obstacles to obtaining the procedure, an obstacle that some women are unable to overcome.<sup>78</sup> Without Medicaid funding for abortion, many women reschedule their appointments while trying to save money or waiting for their partner to fulfill promises to pay.<sup>79</sup> Several of the women interviewed unsuccessfully sought financial help from their partners, sometimes further delaying their abortions. One mother of two reported that “I asked him as soon as I found out and made my decision, and every time he said he would help. He said he would have half of it, and then all of it, and he didn’t. I had to cancel three appointments.”<sup>80</sup> One clinic counselor reported that patients who do not secure funding typically vanish.<sup>81</sup> They may find out that they are further along in their pregnancies than they thought, or that the funding available from abortion Funds or donations to clinics is not enough to close the gap. Typically clinics are unable to track these women, though clinic staff members are certain that some never obtain an abortion for want of funding. Of the 50 to 70 abortion patients that her clinic sees weekly, the counselor stated that around five are unable to obtain the money to pay for the abortion.<sup>82</sup> On occasion, the clinic allows women to give them IOUs, knowing that it is unlikely that the women will ever be able to repay the money.

When **R.L., a 26-year-old single mother, was asked how the availability of Medicaid would have affected her**, she reported that it “would have changed a lot of things for me. If I could have easily been able to go to somewhere local and say, ‘I’m not working anymore, I just found out I’m pregnant, this is my situation, right now I don’t feel comfortable keeping my child, can you help?’ And they said, ‘We can help,’ it would have changed a lot of things for me. I could have gotten away from [my abusive partner] a lot sooner. There was 10 weeks of me having to wait, panicking.”<sup>83</sup> Asked whether Medicaid should cover abortions for poor women, she responded: “I think that the government should definitely help with the cost of abortion... Medicaid should help... [I]t should be an option that

low-income women should have. It could ... change a lot of women’s lives and give hope to young girls who feel like they have no other alternatives.”<sup>84</sup> **(See Box: Punishing Survivors of Domestic Violence.)**

**Other women interviewed spoke of how Medicaid funding would have allowed them to have their abortions earlier, not pay so much for the procedure, pay their bills, and keep their procedures “more confidential.”**<sup>88</sup>

**H.S.** reported that “it’s really, really hard out here. I mean the economy is so messed up, and it’s really hard to get a job and it’s hard to save, and there’s stuff you need for you and your family. Whether it’s your fault or a mistake, they should help.”<sup>89</sup> **T.S.** reported that with the help of Medicaid, “it wouldn’t have taken me so long to get [an abortion]. I wouldn’t have had to miss so much work. It’s not something a woman should run and do every day, but when things come up like mine.... I crossed my Ts, dotted my Is. I was on birth control, and I ran into a financial slump. I wish I would have been able to use my medical card to get the procedure.”<sup>90</sup> For one woman, finding out that Medicaid only covered her if and when she needed prenatal and post-partum care was “something that really upset me. It didn’t make sense to me....just giving me assistance for this pregnancy.”<sup>91</sup>

## FORCING WOMEN TO DELAY ABORTIONS

“If a woman could pay for her abortion right away, she would get it done right away. She wouldn’t wait until she was 18 weeks.... I don’t understand how people think it’s just.... If [abortion is] their legal right but they can’t access it [because they are poor], you’re taking away their legal right.”

— Executive Director of the Chicago Abortion Fund<sup>92</sup>

Poor women are routinely forced to delay their abortions in order to raise enough money to pay for the procedure.<sup>93</sup> On average, it takes them two to three weeks longer than other women to obtain an abortion because of the difficulties involved in procuring the necessary funds.<sup>94</sup> Six in ten economically disadvan-

# PUNISHING SURVIVORS OF DOMESTIC VIOLENCE

## **The Hyde Amendment provides no exception for women experiencing domestic violence.**

The director of the Women's Medical Fund in Philadelphia discussed one woman struggling to deal with the consequences of an abusive relationship.<sup>85</sup>

**I.S. is a 22-year-old woman trying to rebuild her life.** She and her boyfriend had bought a home and started a family. **She had an infant and another on the way when her boyfriend became abusive.** She separated from him, enrolled in a welfare-to-work program, and filed for child support. Her aunt took her and her baby in while she face[d] foreclosure on her home. Although enrolled in Medicaid, she was prohibited from using it for abortion care. **I.S.** pulled together \$125 toward the cost of her abortion and [the Fund] closed the remaining gap with \$145. In her words, "I don't know what I would do if I couldn't get this help. I really didn't have anyone else to turn to ... it will help me a great deal, not only for me but for my family too."

In an interview, **R.L., a 26-year-old single mother who had been working as a personal care aide and attending school full-time to become a registered nurse,** shared her story about how **domestic abuse led to an unintended pregnancy and created financial and other barriers to obtaining an abortion.**<sup>86</sup>

"When I found out [that I was pregnant], I was extremely upset. I have three children from a previous ... abusive relationship. [I thought] I found somebody better for me and my kids and that turned out to be not true. He was a lot worse."

**R.L.'s** boyfriend seemed to be the perfect man, the son of two pastors who came from a well-off family, until they got engaged and he convinced her to quit her job and move to his extremely rural Georgia home. He promised to get health insurance for her and her kids, but he never did. "Within 2 weeks, the abuse began.... I was cut off from everything I knew.... He didn't want me to work, so I was in a situation where I had to depend on him. I had no contact to my family.... He would always threaten to kill me, if I tried to leave.... I was really depressed at the time. It was horrific."

**R.L.** reported that her boyfriend was verbally, physically, and sexually abusive towards her both before and after he learned that she was pregnant. "I thought maybe I could think of something, get away, maybe keep the baby, but it was so hard to get away from him, once he found out all hell broke loose. It got worse. The forcing himself on me got worse, the not giving me food got worse, the taking it out on my kids got worse.... It took me two months to figure out how I was going to get the abortion."

**R.L.** was fortunate to receive financial and logistical help from a neighbor whom she met one day at the local grocery store, while her boyfriend sat in the car outside. "I'm now being stalked by the same guy. I just had to take a restraining order against him. I'm pretty much starting over ... I'm still afraid of him.... I've had friends who have been murdered by ex-boyfriends, who have been shot by their husbands. I've seen that domestic violence up close...."<sup>87</sup>

tagged women who have had an abortion report that they would have preferred to have had the abortion earlier in the pregnancy.<sup>95</sup>

Research shows that approximately 90% of abortions take place in the first trimester.<sup>96</sup> Among the women interviewed, seven obtained first-trimester abortions, while eight obtained second-trimester abortions, two of whom had not yet undergone the procedure at the time of the interview. All but two<sup>97</sup> of the fifteen women interviewed reported delaying their procedures, due in part to their inability to obtain funding or transportation. In several cases, the delay not only increased the cost of the abortion, but changed it from a brief procedure to a two-day abortion. Five women reported having to cancel and reschedule appointments, in some cases pushing them past a clinic's gestational limit or forcing them to undergo a more complicated procedure, and two reported having to forgo receiving anesthesia or pain medication because they could not afford the additional costs.

Many women make the decision to have an abortion immediately upon finding out that they are pregnant, but poverty and the Hyde Amendment's funding restric-

tions force them to delay their abortions into the second trimester. According to one clinic counselor, low-income women get caught in a vicious cycle when they call to inquire about obtaining an abortion, find out the price, get overwhelmed, and put it off. Delay is a direct consequence of the significant financial hardships experienced by poor women. "They lose their jobs, they get behind on their bills, they don't pay their rent. [They] get in a deep hole."<sup>98</sup> **(See Box: Delay Due to State Failure to Fund).**

The Women's Medical Fund reported working with many women seeking second-trimester abortions, with 41% of women requesting financial assistance being 13 weeks or more pregnant.<sup>99</sup> "Our experience is typical of all the abortion Funds, unless ... [they] only fund first-trimester [abortions]."<sup>100</sup> The Fund director attributed the delay to a number of factors, including women spending time chasing funding, while the cost of their abortion continues to climb.<sup>101</sup> The director of the Chicago Abortion Fund, which exclusively funds second-trimester abortions, reported that the average pregnancy gestation among women calling for abortion funding is 18.4 weeks, up from 17.4 weeks last year.<sup>102</sup> "No woman

## DELAY DUE TO STATE FAILURE TO FUND

Delay also occurs in states that, by law, go beyond the Hyde exceptions, but in practice, fund few abortions, leaving women in those states in a similar position to women in Hyde states. **A 21 year-old single mother on Medicaid whose son was 11 months old at the time of the interview,** L.Y. reported that he was born with a birth defect called gastroschisis.<sup>108</sup> One week after her son was born, she stopped working. He spent one and a half months in the hospital and endured a number of surgeries and procedures. She has been trying to

return to work for several months. Because Medicaid pays for very few abortions in her state, she was forced to delay the procedure for two weeks while she tried to get an appointment for the least expensive abortion she could find. She said that, when she finally did so, "they ended up telling me I was too far along to get it done [there]." Needing, at that point, to raise \$850 for the abortion from several abortion Funds, which took another two weeks, **L.Y.** was 17 weeks and 3 days pregnant when she went for her two-day surgical procedure.

## OTHER BARRIERS TO ACCESS

In addition to the Hyde Amendment, low-income women are particularly affected by other legal restrictions on abortion provision and the shortage of abortion providers. **Restrictive laws** and the **lack of providers** compound the financial obstacles women face, driving up the costs and increasing the hardships they must overcome to obtain an abortion.<sup>104</sup>

State restrictions on abortion, such as **24-hour waiting periods** and **parental consent provisions**, restrict the availability of abortion for all women by requiring them to jump through legal hoops before accessing services and by imposing costly and burdensome requirements on women, as well as on providers.<sup>105</sup>

If a woman is delayed in having an abortion for financial or other reasons and passes the gestational limit of the original clinic, an additional obstacle that

she may face is finding a new provider. Individual clinics establish their own guidelines dictating how late they will provide abortions, which must adhere to state regulations on gestational limits and may also be determined by provider availability, facility capacity, and cost. In many states, there is a **shortage of abortion providers**, especially providers who do later abortions. If a woman is delayed by days or weeks, as many low-income women are, this may mean that, in addition to having to pay for a costlier procedure, she will have to incur potentially substantial travel expenses to get to a provider who can provide the abortion. If the provider is in a state that requires a 24-hour waiting period after the provision of state-mandated information, travel expenses could include two trips or an overnight hotel stay, as well as childcare costs and lost wages.

purposefully waits to have a second-trimester abortion. They will keep calling us every week to try to get through to access funding.”<sup>103</sup> (See Box: Other Barriers to Access.)

### PERSONAL ACCOUNTS OF WOMEN'S DELAYS

**For C.M., a 26-year-old single mother and disabled Iraq war veteran, obtaining an abortion was incredibly challenging.**<sup>106</sup> C.M. had disability insurance and healthcare coverage through Veterans Affairs, but also needed to obtain food stamps to cover basic needs. She had recently broken up with her six-year-old son's father and begun getting child support from him. She enrolled in Medicaid early in her pregnancy while deciding whether to have an abortion. As C.M. tried to raise the necessary funds, she was forced to delay her abortion for over six weeks and to cancel several appointments, all while

the cost of the procedure continued to increase. The difficulties of financing and scheduling her abortion rose significantly when the delay required that she undergo a two-day procedure, which meant finding someone to drive her to the clinic and bringing her son on an overnight trip some 80 to 90 miles away. C.M. obtained her abortion just after 20 weeks, which ended up costing over \$1,500 and forced her to borrow funds and forgo paying bills and loan payments.

Like many of the women interviewed, C.M. was working, going to school, taking care of her child, and trying to take care of herself when an unintended pregnancy further complicated her life and burdened her finances:

*“I found out I was pregnant a month or so after conception, and I felt really depressed [and] stressed out. There were a number of issues going on already in my life. Be-*

*ing pregnant was not going to make any of those issues better.... The child that I have, me and his father were together—we moved to North Carolina where he lived to try to give another shot at a relationship and family life but that didn't work out.... The father wasn't around; I had to pay all the bills, all the major responsibilities were on me. I worked at night until 4 or 5 AM, then had a two-hour class from 9 to 11 [in the morning], then also class on certain nights till 9 or 10. Then I'd have to pick my son up at 5 or so, or sometimes not till the next day. It was really stressful. [The father] also took back a lot of things from the relationship so I needed to find a new car, a new place to stay.... I'm also a disabled veteran. I served in Operation Iraqi Freedom.... I was diagnosed with [post-traumatic stress disorder (PTSD)], which I deal with constantly.... I suffered a nervous breakdown in 2006 from PTSD, which is why I was working so hard to get my life back together, because I lost everything at that time."<sup>107</sup>*

In addition to the demands of making ends meet and caring for their families, many women are delayed while searching for an abortion provider they can afford to pay out-of-pocket, and failing that, raising the money that they need. **R.D., a 27-year-old single mother of two children who works part-time and attends school full-time while enrolled in Medicaid and obtaining food stamps,** reported that she was forced to schedule and cancel several appointments as she raised the necessary funds and ended up enduring a two-day procedure.<sup>109</sup> The worry that she would not be able to get the abortion at all, when she knew she couldn't raise another child, caused her great distress. **R.D.** reported that "the waiting was pretty awful. It was on my mind at all times. I lost 30 pounds not being able to eat, not being able to get it off my mind. What if I couldn't get the abortion, what was I going to do? At work and school, I just put on a happy face and did what I had to do. It's harder [to do the same] with [my] kids."

**M.C., a 19-year-old single mother from Texas with two children under the age of two,** was still working to secure funding for her abortion at the time of the interview.<sup>110</sup> She reported working full-time at Burger King, while also attending college full-time with the hope of becom-

ing a registered nurse. She had recently moved back in with her parents, who themselves were struggling financially, and she was not receiving any child support. **M.C.** reported being enrolled in Medicaid and recently being added back onto her parents' food stamps. She went to the hospital in pain thinking that she had a bladder infection, only to discover that her boyfriend had given her a sexually transmitted infection and that she was pregnant. She reported having to reschedule her appointment several times: "When I get my paycheck [I'll reschedule again].... It makes it hard for me because I know what I'm gonna do, and ... I want to act like I'm not even pregnant; it's always on my mind." She reported that she and her mother are very close and that her mother was upset to learn of her pregnancy, "but she knows I can't afford it, so that's why she understands ... [even though] it's against my religion." When she first called to schedule her abortion, she was told that she would be able to have a medication abortion. Due to her financing delays, she was instead preparing to have a surgical abortion and hoping that she would be able to raise enough money to cover the \$25 charge for anesthesia.

## IMPOSING ADDITIONAL FINANCIAL HARDSHIP ON POOR WOMEN

Paying for an abortion imposes significant financial strain on Medicaid-eligible women. In one study, nearly 60% of Medicaid-eligible women reported that paying for an abortion created serious hardship.<sup>111</sup> Moreover, studies have found that poor women are often forced to divert money that they otherwise would have spent on necessities such as rent, utility bills, food or clothing for themselves or their children, and that some women resort to extreme measures such as pawning household goods, theft, or sex work in order to raise enough money to pay for an abortion.<sup>112</sup>

Among the women interviewed, all but one reported difficulties obtaining the funds needed to pay for their abortions, though the degree of difficulty varied dramatically. Twelve women reported receiving private financial assistance to cover their procedures, two were still in the process of sorting out funding at the time of the inter-

view, and one woman attempted to receive assistance but reported difficulties with the process. The majority of the women interviewed reported having to sell or pawn possessions, borrow money, forgo paying bills, give up their cars—if they were able to afford one in the first place—limit their food intake, or make other arrangements in order to cover the balance of their abortions, diverting money from other essential household expenditures. **(See Box: Financial Hardship and Financing the Abortion.)**

Poverty imposes a downward spiral on poor women, who are often working to improve their lives and those of their families. Two of the abortion Fund members interviewed reported working with a large percentage of women who are mothers and virtually homeless. These women are desperate to terminate their pregnancies, even at the risk of gravely harming themselves. The director of the Women’s Medical Fund shared the story

of a woman whom they had recently helped: the young woman said to the Fund’s phone counselor, “I’m thinking of ways I can fall or what I can do to end this pregnancy.”<sup>114</sup> Unable to attend a job training session due to a public transportation strike in November, she had lost her enrollment in the welfare program, and therefore her income. While she worked with her caseworker to re-enroll, she was evicted from her apartment for failure to pay rent. She and her preschooler were taken in by a friend with five children. Although she is enrolled in Medicaid, she cannot use this to pay for her abortion. She received \$100 from her aunt toward the cost of her procedure and the abortion Fund filled the remaining gap with \$113. While this woman was fortunate enough to receive financial assistance and obtain an abortion, thousands more women are unable to obtain help and abortion Funds cannot meet the growing need.

## FINANCIAL HARDSHIP AND FINANCING THE ABORTION

- Nine women borrowed money to pay for their abortions or received help from friends, family or neighbors. Another reported that “my family doesn’t have a lot of money. Everyone is unemployed. They’re all laid off, so they can’t help.”<sup>113</sup>
- All but one of the women obtained financial assistance from either an abortion Fund or through private donations subsidizing care at a clinic, and some women obtained help from both sources and multiple Funds.
- One braided hair for 18 hours over the course of three days, while attending school full-time and sleeping for only three hours.
- One started working extra hours following her abortion to cover the cost of diverting her income from her usual expenses to pay for her abortion.
- One was overdrawn in her checking account and had her phone cut off for several weeks
- One cut back on diapers and clothes for her child.
- Four pawned or sold personal and household items to cover the cost of their abortions, while two reported not having anything worth selling.
- Four reported being unable to pay bills following their abortions or holding off from purchasing basic necessities.
- One family—including the woman interviewed, her two sisters, and her two daughters—was short on food for a week and a half following the woman’s abortion.

While most women who obtain help from an abortion Fund or through a clinic subsidy are able to raise part of the cost of the procedure themselves, many women are unable to do so. According to a clinic counselor, even if “a funding agency gives them \$50 or \$200, it still leaves a huge gap that they are not able to fill.”<sup>115</sup> Some clinics work with women, who are often pushed into desperate situations, to explore their options. “When you’re in that place, it seems so hopeless. Sometimes we can help them by looking at that a little more clearly, stepping back, being more objective.”<sup>116</sup> This counselor reported on the dire circumstance of women seeking to fill the gap between the cost of the abortion and the committed funds, saying that “we have had women who are panhandling in the waiting room to try and come up with their portion. We had a [mother] who was selling everything in the diaper bag—baby formula, diapers, anything she could find, trying to raise money for her co-pay. There was a [nother] woman who worked full-time, and at night she would sell tamales outside on the street ... stay up late making them, go to work, and spend the evening and night selling tamales, trying to raise the money. Desperate women do desperate things. We see the immeasurable strength that women have and the commitment to their families far above themselves.”<sup>117</sup>

Women must come up with money not only for the cost of the procedure, but also for the expenses of traveling to a clinic if abortion is unavailable or too costly where they live or they are delayed into needing a later procedure. **T.D., a full-time college student who works part-time, collects food stamps, and is enrolled in her university’s student health insurance plan**, reported contacting three clinics for her abortion.<sup>118</sup> The local Planned Parenthood had stopped offering surgical abortions the week before and only offered medication abortions until four weeks gestation. The other local clinic refused to accept the abortion Fund’s voucher. In the end, two weeks after contacting the local clinics, **T.D.** travelled two hours each way to a clinic that charged her \$425 for a surgical procedure at nine weeks and accepted the Fund’s payment of \$300. To

get to the clinic, she spent over \$30 in gas and took time off from school, while her mother took the day off from work to accompany her. Her phone was cut off for two to three weeks as **T.D.** was unable to pay the bill due to paying \$125 towards the abortion, which also caused her to be overdrawn in her checking account.

For young women in school, unexpectedly having to find a way to pay several hundred dollars or more for an abortion can be daunting. **E.J., a 20-year-old single mother of a two-year-old boy from Louisiana who is on food stamps, reported that she is the first member of her family to attend college.**<sup>119</sup> During the week, her son lives with her grandmother “so I can go to school and provide a better life for both myself and my son.... I didn’t know that I was pregnant when school started. When I was in high school, I got a dance scholarship to dance at an [out-of-state] college, so I had to pass up the opportunity to go off and dance because I didn’t believe in abortion. I went through with that pregnancy. Now I’m in school and dancing again and I couldn’t afford to support a child.... I can’t go to my immediate family ... because of my religi[ous] background, that’s not acceptable. I’m Baptist. It’s more of a ‘you made your bed now lay in it.’” She reported trying “to do work study on campus, but they denied me.” She also reported trying to get a job off campus, but not having a car made it impossible. In order to cover her portion of the \$475 cost of her abortion, not including the \$50 fee to see the doctor, she used \$160 that she received from her school loan, \$30 that she received from returning a class textbook, and \$95 that she earned from spending 18 hours braiding hair for two people. **(See Box: Low-Income Women Advocating for a Solution.)**

## EXPERIENCES OF WOMEN STRUGGLING TO SURVIVE THE ECONOMIC CRISIS AND OBTAIN AN ABORTION

The full impact of the current economic downturn is still unknown, but reports from women, clinic staff, and abortion Fund activists suggest an increase in both the demand for abortion and for financial assistance,

particularly from recently unemployed women. One counselor reported that “there are a great many more women who are seeking abortions and in need of help. It’s because of the economy, and unemployment has been growing for quite some time.”<sup>122</sup> **(See Box: The Challenges of Assisting Women.)** In addition, three of the women interviewed reported that they were planning to continue their pregnancies until their household finances were affected by their or their spouses’ layoffs. Even in instances where families are entitled to some financial assistance, they may have to wait long periods of time before they can access benefits. One woman reported that it would take six to eight weeks to initiate her husband’s unemployment coverage.<sup>123</sup>

In a September 2009 report by the Guttmacher Institute examining how the recession was affecting

women’s family planning and pregnancy decisions, researchers found that 44% of the women surveyed wanted to reduce or delay their childbearing.<sup>128</sup> At the same time, 23% of surveyed women reported having a harder time paying for birth control, a figure that rose to one in three when considering only the financially “worse-off” women.<sup>129</sup> This data suggests that the recession is also likely to have an impact on the demand for abortion, as women struggle to reconcile their desires for reduced or delayed childbearing with their inability to access affordable family planning methods. Indeed, between 2000 and 2008, the proportion of women obtaining abortions who were poor increased by 60%.<sup>130</sup> In 2008 poor women’s abortion rate was five times that of women who were not poor or low-income.<sup>131</sup>

## LOW-INCOME WOMEN ADVOCATING FOR A SOLUTION

In 2007, the **Chicago Abortion Fund (CAF)** launched a leadership group, ***My Voice, My Choice***, composed of former Fund clients, based on the belief that the women it serves need to be part of the solution. The leadership group, currently 14 members, is made up primarily of young women of color. Group members participate in trainings on leadership development, reproductive justice, and advocacy and research and train fellow group members on relevant topics of interest. **CAF** provides support services to the women in the group, including information and referrals to daycare, housing, and job opportunities. After training, the women join **CAF’s** reproductive justice team and engage in organizing, community education in marginalized communities, and advocacy with elected officials. Many of the

participants have told their abortion and life stories in advocacy and community education settings. ***My Voice, My Choice*** also produces a monthly talk show on abortion access. With support from the Network, the group continues to grow and mobilize locally and nationally for greater access to abortion for low-income women and women of color. **By empowering and supporting the leadership of the women most affected by barriers to access, CAF is helping to build a stronger movement for change.** The executive director reported on the remarkable women who participate in the leadership group, saying that one of the women “is the mother of three young girls. She works a minimum wage job full-time. She just barely covers the rent.... She still finds time to come in and be a part of the group.”<sup>121</sup>

**H.T., a mother of three who lost her job while pregnant, stated that she knew she “couldn’t afford a baby”** given her financial circumstances but had “mixed feelings” about getting an abortion.<sup>132</sup> She reported that she was not able to get unemployment benefits “because the system is out of money, so they are trying not to enroll [new] people.... I applied four times and got turned down. Some people have to go to two [court] hearings to get unemployment,” in addition to going to the unemployment office every day, which would have required getting a babysitter for her four-year-old daughter. At the time of her interview, she had enrolled in food stamps and Medicaid. Shortly after discovering that she was pregnant, while still employed, she went to see her doctor, knowing that her insurance was set to expire two days later. She thought that she was having a miscarriage, having had one in the past, and a blood test at her doctor’s office indicated that this was likely the case. She was unable to schedule an ultrasound to confirm, however. Four weeks later, when she realized that she had not miscarried, she had lost her job and insurance and she needed to raise the

money for an abortion. At 17 weeks and 6 days, she had an abortion. In addition to borrowing money from her sisters and receiving assistance from a Fund, **H.T.** had to delay paying some of her bills in order to pay for her abortion. She still owes the clinic \$185. She owns a home, but does not “think [she’ll] be able to stay there,” since she can no longer afford the mortgage. She makes “arrangements on top of arrangements, but it’s not enough.”

**T.S., an unhappily married, 38-year-old mother of two from Pennsylvania,** reported working full-time for a state-funded mental health association, being enrolled in Medicaid, and taking the pill regularly at the time of her unintended pregnancy.<sup>133</sup> When she found out that she was pregnant, she was working on furlough and not receiving any income because the state budget had not been passed by the legislature. In addition to receiving assistance from the clinic and a Fund, and using some money set aside from what her sister sends to help out, she borrowed money from two of her colleagues in order to finance her abortion, telling

## THE CHALLENGES OF ASSISTING WOMEN

**The economic downturn has had a dramatic impact on the need for abortion funding, with Network abortion Funds reporting increases of 50–100% in requests for help from women over the past few years.<sup>124</sup>**

While Funds raised approximately the same amount in 2009 as in 2008, many more women requested assistance and many women needed larger sums of money to close the gap between their own resources and the cost of the abortion.<sup>125</sup> Some Funds also found that their donors had lost significant amounts of savings and were unable to contribute as

much as in years past. Other Funds were able to dramatically increase their fundraising to meet the rising need.<sup>126</sup> In a recent survey of its member Funds, the Network reported that members received 87,000 calls requesting assistance from women between July 2008 and July 2009.<sup>127</sup>

them that she needed it for groceries. Her husband is mostly unable to work due to a work-related injury sustained four years ago and financial issues have strained the marriage. “I didn’t tell anyone at the time [about the pregnancy and the abortion] ... I honestly think that I made the right decision for myself and my household.... I was really, really sick during my pregnancy, dehydrated. [She reported being hospitalized for dehydration and vomiting.] I had a lot of mixed emotions.” **T.S.** went back and forth about the decision to terminate the pregnancy, but in the end she and her husband concluded that another child would put too much strain on their financial situation and cause problems for the family. “[My husband] knows that a baby would bring complications and problems on the home, let alone expenses.”

**For a 20-year-old mother from Pennsylvania, who at the time of the interview had a six-month-old daughter, the decision was incredibly difficult.**<sup>134</sup> **H.S. found out that she was pregnant when her daughter was just two months old.** At the time that she became pregnant, she was on the NuvaRing (a hormonal contraceptive) and in school full-time earning an associate’s degree in computer technology. She had gone back to school because she had not been able to find another job as a certified nursing assistant after her daughter was born; she had quit her prior job when she was eight months pregnant because she was too ill to work. “Nobody was hiring.... I couldn’t get a job.” She wanted to continue with the pregnancy, but she knew that she could not support another child without any income besides public assistance; her mother, with whom she lived temporarily while getting on her feet, supported her decision. She would like to have more children after she gets her degree and is financially stable. At the time of the interview, she was getting ready to start a new job part-time.

## PRESSURING WOMEN TO CONTINUE UNWANTED PREGNANCIES

Approximately one in four women on Medicaid who wants to have an abortion is forced to continue her

pregnancy because she cannot afford to pay for the procedure.<sup>135</sup> This estimate is based on a number of studies published since the Hyde Amendment went into effect 34 years ago, which found that between 18 and 37% of women who would have obtained an abortion if Medicaid funding had been available instead continued their pregnancies to term.<sup>136</sup> One of the most respected studies analyzed the abortion and childbirth rates in five instances in which an abortion fund created by the North Carolina state legislature ran out of money before the end of the fiscal year.<sup>137</sup> It concluded that 37% of women who would have had an abortion if money had been available through the abortion fund instead carried their pregnancies to term.<sup>138</sup>

When asked if they had any knowledge of what happens to women who are unable to obtain funding for their abortion procedures, Fund members and clinic counselors responded that there is little if any mechanism to track these women, with one Fund member saying “it makes sense to believe that if a woman can’t get an abortion because she couldn’t pay for it, she ends up having a baby.”<sup>139</sup> Clinic counselors report that a certain percentage of women who make appointments do not show up for them, with one saying that her clinic has a no-show rate for the state-mandated informed consent sessions that ranges from 32–43% per month and a 20% no-show rate for abortion appointments.<sup>140</sup> If there is no further contact, then there is no way to know what happened. One counselor said that staff may eventually reach about 10% of women who do not reschedule appointments, most of whom report having financial issues.<sup>141</sup> Some women keep rescheduling until they raise the necessary funds, while others give up trying, look for a clinic that performs later abortions, or change their minds altogether. Another counselor reported that “very few women actually tell us ‘Well, I changed my mind.’”<sup>142</sup> If they do, the clinic tries to get them prenatal care. “Sometimes they say they would rather have had an abortion but they can’t raise the money.”<sup>143</sup>

Asked how the repeal of the Hyde Amendment would affect poor women, another counselor reported that the women would no longer have to forgo needed abortions because they would have access to this essential healthcare service: “Women who can’t afford to have children, but are forced to go through with the pregnancy because [they] can’t come up with the money to pay for the abortion, that would change dramatically.... I simply have never been able to understand why abortion ... is not included in a woman’s reproductive healthcare. It’s a fact of life. Abortion has always

existed. It’s always going to exist.”<sup>144</sup> (See Box: **The Financial Implications of Unwanted Pregnancies Carried to Term.**)

## ACCESSING MEDICAID FUNDS UNDER THE HYDE AMENDMENT EXCEPTIONS

Discussions with providers in a few Hyde states suggest that, even for women who are victims of rape, incest, or have life endangering situations, the challenges of obtaining Medicaid approval and the lengthy

# FINANCIAL IMPLICATIONS OF UNWANTED PREGNANCIES CARRIED TO TERM

**“I don’t want to depend on the system to help raise my child.**

**What if the system isn’t there?”** — *Pennsylvania woman interviewed for this report*<sup>145</sup>

Women should not be coerced into bearing children because of abortion funding bans, nor should they be prevented from having children because of punitive or inadequate social and economic supports for low-income women and families. However, as state and federal governments debate how to contain Medicaid costs, it is important to note that, although repeal of the Hyde Amendment would require Medicaid to fund additional abortion procedures, the overall budgetary effect of allowing poor women to use Medicaid to pay for abortion would be a decrease in federal and state spending. The costs associated with unwanted pregnancies carried to term are estimated to be four to five times greater than those of paying for abortions for women who seek them.<sup>146</sup> The available data suggests that providing public funds for women seeking abortion would result in signifi-

cant cost savings for federal and state governments. The most widely cited study concluded that using state and federal funds to pay for abortions would have resulted in medical and social welfare savings of \$435 to \$540 million and a net savings to the nation of at least \$339.6 million over the two years following the study.<sup>147</sup> The same study concluded that, for every dollar spent to pay for abortion, nearly five dollars are saved in public medical and welfare expenditures related to babies born to poor women, including Medicaid expenditures for prenatal care, delivery, and postnatal care for the mother, as well as newborn care, neonatal intensive care, pediatric care, food stamps, and public assistance for the child during the first two years of life.<sup>148</sup> The study was replicated with similar results.<sup>149</sup>

bureaucratic process often preclude most eligible women from obtaining payment for their abortions. At least two of the women interviewed reported having been raped by their sexual partners, though neither of them received Medicaid funding for their abortions.<sup>150</sup> Eleven of the women interviewed reported having some previously diagnosed health condition or a pregnancy-related health condition, which in a few cases involved being hospitalized. While it is unclear how many of these women might have fallen into the category of life endangerment, not one of them received Medicaid funding for her abortion.

Available data suggests that it is highly unlikely that any of these women would have had their abortion paid for with public funds if they had sought funding under Medicaid. In fiscal year 2006, twenty-four of the 33 Hyde and Hyde-plus states did not spend any money on abortions.<sup>151</sup> Public spending in the remaining nine states totaled \$457,000.<sup>152</sup> That year, the federal government paid for only 54 abortions in Hyde states and 31 in Hyde-plus states.<sup>153</sup> A study published in 2010 by Ibis Reproductive Health interviewed representatives of 25 providers in six Hyde states. Researchers found that, of 245 reported abortions that should have qualified for reimbursement in the previous year, more than half (143) were not reimbursed; of those that were, 97% were in one state.<sup>154</sup> Barriers to reimbursement included extensive administrative burdens, nonexistent or poor relationships with state Medicaid staff, low reimbursement rates, and difficulties identifying and certifying rape cases and meeting excessively strict or arbitrary requirements for establishing life endangerment.<sup>155</sup> As a result, eight of the 25 providers had stopped accepting Medicaid within the past five years.<sup>156</sup> Twenty-three of the providers reported relying on abortion Funds to help women pay for abortions.<sup>157</sup>

For minors who are victims of rape or incest, one provider interviewed for the report explained that seeking Medicaid funding is not feasible, because these young women are emotionally traumatized and do not have the luxury of time. They are unable to go through the (re)traumatizing experience of reporting and certifica-

tion necessary for receiving Medicaid funding under the Hyde exceptions and to continue their pregnancies for weeks while awaiting approval from Medicaid.<sup>158</sup> In such cases, the provider reports that she does what she can to secure funding, offers discounts, or waives fees if absolutely necessary.<sup>159</sup> The provider related a case where a minor was the victim of rape that occurred when she went out of state to visit her mother, hoping to reestablish their relationship, and returned pregnant by the mother's boyfriend. The local law enforcement was so moved by the girl's situation that they took up a collection to pay for her abortion.

A provider from Pennsylvania reported that when she started working with the clinic as a receptionist and counselor in 1994, the legal requirement that Medicaid reimburse clinics for abortions performed in case of rape, incest, or life endangerment was "meaningless," but that things have improved somewhat.<sup>160</sup> In the 1990s, the clinic did not get reimbursed and so it did not work with Medicaid, as the provider believed was the case with other providers in the area. She went on to report that "years later, when I was in a position to advocate directly for patients with the state with the backing of my center, we were able to secure some basic payment for these patients. This has always taken a great deal of time and effort, and payment continues to be unreliable, though much better than a decade ago."<sup>161</sup> **(See Box on p. 39: Helping Women Access Abortion in a Hyde State.)**

# NON-DISCRIMINATION STATES

“In states where state Medicaid pays for all or most abortions, the state plays a fundamental role in ensuring that low-income women are able to obtain abortion care. Many challenges remain, however.”

Seventeen states fund all medically necessary abortions under Medicaid using state funds. In thirteen of these states, state courts have found that the Hyde restrictions violate state law. The importance of state Medicaid expenditures in granting women access to abortion cannot be overlooked. In fiscal year 2006, non-discrimination states paid approximately \$89 million and covered nearly all of the more than 177,000 publicly funded abortions.<sup>163</sup> In 2008, 20% of all women obtaining abortions in the United States used Medicaid funds to pay for their procedure; almost all of those women lived in non-discrimination states.<sup>164</sup> Among women with private insurance, only about a third used their insurance to pay for their abortions, while 92% of women receiving Medicaid in states that use their own funds to cover abortion relied on the state program for payment.<sup>165</sup>

In non-discrimination states, state Medicaid programs cover abortion just like any other healthcare service. Moreover, some non-discrimination states, such as New York, have policies designed to facilitate pregnant women’s access to prenatal care (often called “presumptive Medicaid”), which can also be of advantage to women seeking abortion, as a way to address the time constraints pregnant women face and the resulting delay when women have to wait weeks for Medicaid eligibility determinations.<sup>166</sup> For example, a Washington State provider interviewed for this report commented that her state “has a very flexible policy to get [pre-

sumptive] Medicaid. Women can get [presumptive] Medicaid for pregnancy, [and] can use [it] for prenatal care or abortion. It is extraordinarily rare for a woman who [is] pregnant to not get on [presumptive] Medicaid.”<sup>167</sup>

While the Medicaid coverage for abortion in non-discrimination states is significant and laudable, states’ ability to enable women to actually access abortion coverage varies. Barriers to enrollment, such as cumbersome processes and misinformation, make it difficult for women to enroll in Medicaid even in states where efforts have been made to simplify and expedite the application process. Women also face obstacles resulting in the denial of eligibility or improper coverage restrictions. In non-discrimination states, there are barriers for providers seeking to accept Medicaid that adversely affect women’s access to abortion. Low reimbursement rates and lengthy or singular processes for payment of claims for abortion services make it difficult, if not impossible, for some providers to receive payment from the state; as a result, many providers will not accept or stop accepting Medicaid patients. Given the increases to Medicaid rolls and the further financial strain on low-income women posed by the economic downturn, it is incumbent on states that have made a commitment to abortion access for poor women to improve Medicaid implementation in their states so that it truly provides access to all healthcare services for women, including abortion.

## STATE COURT DECISIONS ESTABLISHING THE RIGHT TO FUNDING

Thirteen of the non-discrimination states fund abortion under state Medicaid programs due to a court order. The courts in these states have refused to follow the Supreme Court's reasoning in *Harris v. McRae*, finding instead that, under their state constitutions and laws, restrictions on public funding for abortion similar to the Hyde Amendment violate women's fundamental rights. Those state courts' decisions highlight several key legal and ethical problems with the Hyde Amendment.

First, state courts found that it is unlawful for a poor pregnant woman to "be coerced into choosing childbirth over abortion by a legislative funding policy."<sup>168</sup> Put another way, once a government chooses to provide funds to assist a constitutionally protected decision, such as the decision whether to continue or terminate a pregnancy, "it must do so in a non-

discriminatory fashion, and it certainly cannot withdraw benefits for no reason other than that a woman chooses to avail herself of a federally granted constitutional right."<sup>169</sup> Thus, as numerous state courts have explained, by denying poor women the funds to exercise their constitutionally protected right to choose to have an abortion, the government both discriminates against poor women and impermissibly coerces them to choose to continue a pregnancy.

State courts have also criticized restrictions on public funding for abortion as "antithetical" to the goals of a state Medicaid program, which is to provide the poor "with access to medical services comparable to that enjoyed by more affluent persons."<sup>170</sup> By essentially barring a poor woman from obtaining medically necessary abortion care, restrictions on Medicaid funding for abortion "subject[ ] the poor woman to significant health hazards and in some cases to death[,]"<sup>171</sup> and thus clearly contravene the objectives of Medicaid.

## HELPING WOMEN ACCESS ABORTION IN A HYDE STATE<sup>162</sup>

The **Women's Medical Fund** and the **Women's Law Project** work together to combat Pennsylvania's onerous reporting requirements for accessing Medicaid funding for abortions under the Hyde Amendment restrictions. In the 1990s, the two groups worked to ensure that women would not have to report a rape to the police in order to obtain Medicaid coverage for abortion. This requirement deters many women from seeking funding because they have been assaulted by partners, family members, or others whom they know and are afraid of retaliation or reluctant to involve the criminal justice system; others want to put the experi-

ence of sexual assault behind them. In 2000, they collaborated with the health education organization *CHOICE* to work to minimize the obstacles facing women and providers seeking coverage for eligible abortions. Most recently, in 2006, with support from the **National Network of Abortion Funds**, the coalition worked to improve education around the availability of Medicaid funding for abortions under the Hyde exceptions, while also working to revise and advocate for improvements to the state's abortion certification form.

Lastly, state courts have based their decisions to overturn restrictions on public funding for abortion on a defense of women’s right to privacy, which includes a woman’s right to choose to terminate a pregnancy.<sup>172</sup> Those courts interpreted their state constitutions as offering greater protections for privacy rights than the U.S. Constitution, at least as interpreted by the U.S. Supreme Court in *Harris v. McRae*, and thus held that denying public funding for abortion services impermissibly infringed upon women’s fundamental right to privacy and self-determination.<sup>173</sup> The California Supreme Court wrote that “the restrictions effectively nullify the poor woman’s fundamental constitutional right to retain personal control over her own body and her own destiny.”<sup>174</sup>

## FACILITATING WOMEN’S ACCESS TO MEDICAID COVERAGE FOR ABORTION

When women are considering terminating their pregnancies, the expediency of Medicaid enrollment and the duration of time between enrollment and the start of coverage are important issues in determining whether they can obtain an abortion in a timely manner. Unless state policies address these issues, delays in accessing Medicaid benefits can undermine women’s ability to get an abortion or force them to suffer significant delays in obtaining the procedure. Some states, like New York, have programs that facilitate low-income, pregnant women receiving Medicaid benefits and accessing reproductive healthcare, including abortion. Through the Prenatal Care Assistance Program (PCAP), a pregnant woman may receive healthcare benefits immediately after applying for Medicaid benefits, and for the following 45 days, without having to wait for an official determination that she is eligible for Medicaid benefits.<sup>175</sup> In order to take advantage of PCAP, a pregnant woman must simply undergo a brief financial assessment by a qualified provider—which may be a community health clinic, a home health agency, or a public health nursing service—to determine whether, based on guidelines issued by the New York State Department of Health, she may be considered “presumptively eligible” for Medicaid.<sup>176</sup> Other states also make presumptive Medicaid available

to pregnant women to address enrollment obstacles.

Another notable feature of New York’s Medicaid program is that it covers transportation costs for patients to and from medical appointments.<sup>177</sup> In addition, the state Medicaid program offers a “facilitated enrollment program” through which program staff provides personal assistance to Medicaid applicants to help them accurately complete paperwork and assist them throughout the application process.<sup>178</sup>

## PERSISTENT BARRIERS TO MEDICAID COVERAGE FOR PREGNANT WOMEN

Even in states that provide broader coverage for abortion than the Hyde or Hyde-plus states and presumptive eligibility, women can face substantial challenges in accessing benefits. Abortion providers and abortion Funds reported working with women to provide them critical information about available resources and services, existing programs, and eligibility and enrollment requirements. Providers and Funds often work with women to correct the misinformation that they receive from local social service caseworkers who either intentionally or unintentionally deny eligibility, discourage enrollment, or restrict coverage. As one provider said, “[W]omen need to know their state law.”<sup>179</sup> Abortion Funds in non-discrimination states regularly assist women with enrollment in Medicaid and also provide referrals for other services that women often need, including housing assistance and help escaping domestic violence. A provider in West Virginia reported that “a lot of people in this state don’t even realize that Medicaid pays [for abortion]. So we do a lot of educating [of] women who call us and ask about assistance.”<sup>180</sup>

Even in states with simplified enrollment and presumptive eligibility, women can still face difficulties when trying to enroll and struggle to receive coverage in a timely manner. In California, the process for enrolling in the Restricted Pregnancy Medi-Cal program is theoretically faster than that required for enrolling in Full-Scope Medi-Cal, California’s state Medicaid program. In practice, enrolling is more challenging than

the guidelines suggest. According to ACCESS/Women's Health Rights Coalition, an abortion Fund and reproductive justice group in California, "[M]ost uninsured women qualify for Medi-Cal but encounter cumbersome eligibility application processes, rampant misinformation about standard application requirements, frequent case processing delays, and, more recently, onerous identity documentation adopted as a result of the Federal Deficit Reduction Act of 2005. Even for those women deemed Medi-Cal eligible, it is increasingly difficult to find local reproductive healthcare providers, particularly abortion providers, who will accept Medi-Cal to cover the cost of care."<sup>181</sup> While abortions are legal in California up to 24 weeks, only 53% of 148 publicly advertised providers accept Medi-Cal during the first trimester and only 20% up to 20 weeks gestation, with a significant drop off to just 4% after 21 weeks.<sup>182</sup> The varying determinations of acceptance of Medi-Cal for abortion coverage leads women to believe that either they are no longer eligible, or that other clinics will not accept Medi-Cal past that point, or that they must raise the funds and find another clinic.<sup>183</sup>

Although enrollment in Restricted Pregnancy Medi-Cal should only take one week, according to ACCESS, the process often takes much longer. The staff member interviewed heard reports of caseworkers who intentionally delayed the enrollment process, due to an expressed dislike of women using their coverage to pay for an abortion.<sup>184</sup> The ease of enrollment often depends on the individual social services office where the woman applies. For some, enrollment could happen on the same day; others might not be told about Restricted Pregnancy Medi-Cal at all or an eligibility worker might unintentionally attempt to enroll them in Full-Scope Medi-Cal, which has stricter eligibility requirements and an application process that can take 45 days or longer. In these cases, women face unnecessary delays in obtaining an abortion.

The staff member shared the following accounts of trying to help two women enroll in Restricted Pregnancy Medi-Cal:<sup>185</sup>

*I worked with a woman who went to apply for Medi-Cal.... She was early on in her pregnancy, still in her first trimester.... She went to apply for Medi-Cal, but was told by her eligibility worker that she should go and get a job. The eligibility worker was really giving her a hard time for applying for Medi-Cal even though she qualified—that's what the program is for; it's for women like her. She was being told that she should get a job and was made to feel guilty for wanting to get an abortion, for wanting to support the family that she had.... So we tried to call the eligibility worker with her. Of course, we had such a hard time getting in touch with anyone. The woman we were working with kind of didn't want to deal with it anymore and asked us to not go through with it, because she had been so embarrassed by the fact that she was told to get a job and felt like she really shouldn't be on Medi-Cal. We decided that we would help her with some funding to pay.... We had arranged everything, she had an appointment, and she didn't show up because she said she had decided she was too far along and also because she didn't think that she could go through with it anymore. It was just one woman who told her that she should get a job and other things that didn't make her feel good about her decision. She ended up keeping the pregnancy. I don't think she ended up enrolling.*

*There was another woman.... She had applied for Medi-Cal a while back and had called us because ... they were having a really hard time processing her case. There was an eligibility worker accusing her of living with her ex-partner. She was in the process of being divorced and was not living with him at the time and shouldn't have needed to include him in her income. ... [T]hey had sent an investigator from the Medi-Cal office to her house.... She was eventually told that she would need to file a court hearing to dispute her case. She didn't have the time because this would take months to do [and delay the abortion], so we had pledged some amount towards her procedure and she raised some funds, and she had the procedure done, everything was fine. She was really angry about the situation and decided that even though she received*

*funding, she would still try to get this Medi-Cal thing figured out so in the future women wouldn't have to go through it.... She filed the court hearing, she went to court, called us a few months after, and told us that she was able to finally get Medi-Cal and the report definitely showed that the investigator didn't find anything and the eligibility worker was not wanting her to get the Medi-Cal for whatever reason.*

## THE CHALLENGES OF PROVIDER REIMBURSEMENT IN NON-DISCRIMINATION STATES

In states where state Medicaid pays for all or most abortions, the state plays a fundamental role in ensuring that low-income women are able to obtain abortion care. Many challenges remain, however. While some Medicaid programs work well and provide sufficient reimbursement to providers, in other states providers often struggle to recoup the costs of caring for women enrolled in Medicaid due to low reimbursement rates, lengthy processes for receiving payment, and, in some states, a claim submission process that is unique to abortion services. Other challenges in non-discrimination states include the reality that many providers do not accept Medicaid, so it can be difficult for poor women to find care. In addition, narrow Medicaid eligibility rules that exclude many women in need, including immigrants in most states, means that thousands of low-income women in non-discrimination states must still turn to abortion Funds for assistance. While low-income women in non-discrimination states have easier and greater access to abortion, the challenges for providers in obtaining adequate and timely reimbursement from state Medicaid programs have significant implications for the availability and cost of reproductive healthcare services.

## PROVIDER EXPERIENCES WITH MEDICAID REIMBURSEMENT

Interviews with independent abortion providers in three non-discrimination states—Maryland, Washington, and West Virginia—provide examples of the range of state

approaches to administering and reimbursing abortion claims under Medicaid and insight into the degree to which states are abiding by their legal obligations to fund abortion services.

State Medicaid coverage for abortion in the three states varies both with respect to the process for submitting reimbursement claims and the means by which states determine what services to cover, how much to pay for services, and for what type of facility. Maryland is a state that makes it very difficult for providers seeking reimbursement for abortion services, and treats those claims differently than billing for other medical services. For example, abortion providers are required to submit each abortion claim manually, though claims for other services covered by Medicaid are submitted electronically.<sup>186</sup> The attending physician is required to sign each abortion claim; due to ambiguities in the submission process, the provider interviewed reported having to submit each claim approximately five times and being forced to hand-deliver documents, since even those sent by certified mail were reportedly not received.<sup>187</sup> Surgical abortion claims reportedly took an average of nine months to get paid.<sup>188,189</sup> Moreover, the process for reimbursement can be arbitrary and highly dependent on staffing of the state Medicaid office. At one point, the Maryland provider wrote to her Congressman and local leaders. In response, she received a call and a check for \$80,000 in back payment. For a short time, the medical assistance office even had a designated person to handle abortion claims. Shortly thereafter, the staff person was reassigned and reimbursements once again slowed practically to a halt, before the clinic ceased accepting Medicaid patients.

By contrast, in West Virginia, the provider interviewed reported that the process for submitting reimbursement claims for abortion is no different from that used for other healthcare services.<sup>190</sup> “The checks come in a timely manner” and are direct deposited.

While providers in some states receive fairly reasonable reimbursement rates, other providers find that it

is difficult, if not impossible, to recoup their costs for providing abortions due to low reimbursement rates and exclusions of abortion-related services from reimbursement. In West Virginia, the state pays a flat rate of \$277.51 for all abortions but provides additional reimbursements for supplemental services.<sup>191</sup> In Maryland, the state Medicaid program requires that abortions and all accompanying services, such as ultrasounds and lab work, be submitted with one reimbursement code, meaning that the state pays the same rate for all abortions, but regardless of any related services provided, unlike West Virginia.<sup>192</sup> In the case of Washington, considered one of the best states for reimbursements, the provider reported that supplemental services were reimbursed on an unreliable basis: “While checks would come every Friday, sometimes they were for gynecology and abortion services four to five weeks prior, while billings from three to four months prior still had not been paid.”<sup>193</sup>

Due to low reimbursement rates and attenuated reimbursement times, it may not be feasible for some providers, even in states that reimburse most abortions and related services under Medicaid, to serve a high proportion of women enrolled in Medicaid. Seventy percent of the Washington provider’s patients were on Medicaid in 2005, up from 59% the previous year.<sup>194</sup> The Medicaid rate for first-trimester abortions was \$275 in 2006, up from \$127.95 in 1987. With two-thirds of their patients coming for abortion services, the low Medicaid reimbursement rate was increasingly unsustainable. Over time, the clinic, which had always been dedicated to serving “the underserved and marginalized” and known as “the poor women’s clinic,” could no longer support its changing client base. Indeed, prior to the clinic’s closing in January 2007, it was giving away \$1 million in abortion services annually, nearly the annual operating budget.

Taking a different approach, the Maryland provider reported temporarily ceasing to accept Medicaid for a year and a half because the slow reimbursement process nearly forced them to close the clinic.<sup>195</sup>

She had realized that the clinic was spending 50–60% of its time trying to collect Medicaid reimbursements and had lost several hundred thousand dollars in services. In recent months, the provider has noted a rise in women enrolled in Medicaid seeking care at the clinic—now between 50–60% of all telephone inquiries, up from 33%. She largely attributed this to the economy and a reduction in the number of clinics in the state accepting Medicaid. The provider is eager to resume coverage for the underserved and growing population of women enrolled in Medicaid, who face numerous barriers accessing services, including the scarcity of providers. In preparation to resume accepting Medicaid payments, the clinic has had to establish a process whereby it can withstand the financial implications of a nine-month reimbursement delay.

The seventeen non-discrimination states play a critical role in providing access for tens of thousands of poor women to timely and affordable abortion services. However, in many of these states, like the three discussed here, affirmative reform is necessary to ensure that barriers to Medicaid eligibility and enrollment will not prevent women from being enrolled in Medicaid and receiving covered services. State action is also needed to ensure that reimbursement rates and attenuated and discriminatory processes do not deter abortion providers from being willing and able to provide abortions for women enrolled in state Medicaid programs. Otherwise, with access to Medicaid denied to some eligible women and many abortion providers unwilling to participate in Medicaid, non-discrimination states fail to realize the mandate of their own laws to safeguard and promote the reproductive rights of poor women.

# HUMAN RIGHTS FRAMEWORK

“If there was the reinstatement of Medicaid funding for abortion, low-income women would be able to pursue their dreams, move forward in their lives, and exercise the same right to choose that middle-class women can. Women would be able to turn their lives around. It would just make all the difference for women.”

— Executive director of the Women’s Medical Fund<sup>196</sup>

The Hyde Amendment violates the human rights of poor and low-income women. The restrictions interfere with a woman’s right to make fundamental decisions about her body, to access health services necessary to protect her health, and to decide whether and when to have children. The ability to make these decisions without government coercion is integral to women’s dignity and equality. The government’s failure to respect and ensure these rights violate a woman’s right to health, life, equality, information, education, and privacy, as well as freedom from discrimination.<sup>197</sup> **(See Box: the United States’ International Human Rights Obligations.)**

## RIGHT TO HEALTH AND LIFE

International human rights bodies have recognized that governments have an obligation to ensure that individuals have meaningful access to fundamental rights. Protection of women’s rights to health and life require the U.S. government to ensure that safe and legal abortion services are accessible to women. The UN committees that oversee compliance with the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the International Covenant on Civil and Political Rights (ICCPR) have consistently criticized restrictive abortion laws as a violation of the right to life.<sup>205</sup> In particular, the Committee on the

Elimination of Discrimination against Women (CEDAW Committee) has expressed concern where women do not have access to safe abortion services, despite those services being legal, and has recommended that governments provide safe abortion services or ensure access where permitted by law,<sup>206</sup> including recommending that a government provide social security coverage for abortions<sup>207</sup> or include abortion coverage in government health services.<sup>208</sup>

The right to health includes “the right to attain the highest standard of sexual and reproductive health.”<sup>209</sup> To fulfill this right, governments must provide access to “a full range of high quality and affordable healthcare, including sexual and reproductive services.”<sup>210</sup> This obligation includes a responsibility to make reproductive health facilities, goods, and services economically accessible,<sup>211</sup> and in particular, to ensure that such health services are accessible to marginalized or underserved communities.<sup>212</sup>

The funding restrictions imposed by the Hyde Amendment force some poor women to delay abortion or continue an unwanted pregnancy, even when their health is endangered. By limiting or denying women’s access to safe and legal abortion care, Medicaid fund-

ing restrictions also deny women access to a basic component of reproductive healthcare, thus hindering enjoyment of the conditions that are necessary for good health.

## RIGHT TO EQUALITY AND NON-DISCRIMINATION

Restricting access to abortion, a procedure that only women need, discriminates against women and their reproductive freedom. Denying Medicaid funds for abortion services uniquely discriminates against low-income women and prevents them from realizing the full range of rights to the same extent as men or women of greater means. As recognized in the Beijing Platform for Action, “The ability of women to control their own fertility forms an important basis for the enjoyment of other rights” and “neglect of women’s reproductive rights severely limits their opportunities in public and private life, including opportunities for education and economic and political empowerment.”<sup>213</sup> In states where state Medicaid covers abortion services without the restric-

tions of Hyde, this discrimination too often takes a different form, as many women still struggle to access coverage and receive benefits in the face of misinformation, stigma, and bias among enrollment officers.

The international human rights community recognizes a governmental responsibility to ensure that all people, without distinction as to race, national or ethnic origin, or color, have the right to “public health [and] medical care.”<sup>214</sup> The right to non-discrimination in health includes equal access to reproductive health services for women of color.<sup>215</sup> Thus, the Committee on the Elimination of Racial Discrimination has called on governments to report on measures taken to eradicate gender-related racial discrimination in the area of reproductive and sexual health,<sup>216</sup> and specifically urged the United States to adopt special measures to address persistent racial disparities in reproductive healthcare.<sup>217</sup>

Because they more often live in poverty, women of color have a greater reliance than white women on

## THE UNITED STATES’ INTERNATIONAL HUMAN RIGHTS OBLIGATIONS

The rights to life, privacy and personal autonomy, and non-discrimination are set forth in two human rights treaties ratified by the United States: the **International Covenant on Civil and Political Rights (ICCPR)**<sup>198</sup> and the **Convention on the Elimination of All Forms of Racial Discrimination (CERD)**.<sup>199</sup> Treaty ratification confers an international legal obligation on the United States to respect, protect, and fulfill the rights contained in the treaty<sup>200</sup> and to create the conditions necessary to ensure that all persons are able to enjoy rights in practice.<sup>201</sup>

The United States is also a signatory to key human rights treaties that guarantee women’s right to reproductive healthcare and equality—among them, the **International Covenant on Economic, Social and Cultural Rights (ICESCR)**<sup>202</sup> and the **Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)**.<sup>203</sup> The United States has an obligation not to take any action that would defeat the object or purpose of the treaties it has signed.<sup>204</sup>

government services for low-income individuals such as Medicaid.<sup>218</sup> Thus, Medicaid funding restrictions on abortion disproportionately affect women of color.<sup>219</sup> The removal of those restrictions constitutes one measure that would contribute to addressing the significant race disparities in reproductive healthcare by facilitating equal access to abortion.

## **RIGHT TO REPRODUCTIVE SELF-DETERMINATION**

Support for women's right to reproductive self-determination derives from provisions in a number of human rights instruments, which ensure autonomy in decision-making about intimate matters, including protections of the long-recognized rights to physical integrity,<sup>220</sup> to privacy,<sup>221</sup> and to freely and responsibly decide the number and spacing of one's children.<sup>222</sup> Self-determination in decision-making is also inherent in the right to health. The Committee on Economic, Social and Cultural Rights has stated that reproductive health means "that women... have the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice as well as the right of access to appropriate healthcare services."<sup>223</sup> The CEDAW Committee has stated that respect for women's human rights requires governments to "refrain from obstructing action taken by women in pursuit of their health goals."<sup>224</sup>

By interfering with poor and low-income women's decision-making on whether to continue a pregnancy, and placing financial obstacles in the path of women who seek to protect their health and access an essential reproductive health service, the government's restriction on federal Medicaid funding for abortion contravenes women's right to reproductive self-determination.

# CONCLUSION

“After 34 years of harmful—and, in some cases, devastating—discrimination against poor women, repealing the Hyde Amendment offers the United States a critical opportunity to restore women’s equality and make reproductive rights meaningful for all women irrespective of economic status.”

The investigation conducted by the **Center for Reproductive Rights** documents the ways in which poor women are affected by the Hyde Amendment’s discriminatory restrictions prohibiting Medicaid funding for abortion. The findings in this report suggest that if low-income women truly were able to exercise their reproductive rights, including the right to access healthcare services, women would secure an abortion as soon as they could after making their decision. By restricting access to abortion, the Hyde Amendment violates their fundamental human rights and denies their reproductive autonomy. Moreover, even within the limited parameters permitted by Hyde’s restrictions, eligible abortion claims are denied or rejected by states. The women interviewed for this report, and the clinic counselors, providers, and abortion Fund members who told their stories, offer insight into the struggles that poor women face in obtaining abortions, which they often seek in an effort to preserve and protect the health and well-being of their families.

In non-discrimination states where state funds cover abortion without the Hyde restrictions, individual state procedures for submitting and reviewing abortion claims often treat abortion differently than other medical procedures. Moreover, low Medicaid reimbursement rates and attenuated reimbursement times are among the most common factors reportedly leading abortion providers to limit acceptance of Medicaid or refuse it altogether. As a model for state Medicaid

coverage in the wake of Hyde’s repeal, these states need to reform and streamline their abortion payment procedures so that they are in accordance with state standards for submitting, reviewing, and processing all other medical claims. They also need to increase Medicaid reimbursement rates for abortion and related services.

After 34 years of harmful—and, in some cases, devastating—discrimination against poor women, repealing the Hyde Amendment offers the United States a critical opportunity to restore women’s equality and make reproductive rights meaningful for all women irrespective of economic status. Free from the restrictions of Hyde, women throughout the country would be empowered to make decisions regarding what is best for themselves and their families. The time for reform is now. Poor women have waited too long to be treated with dignity and justice.

# RECOMMENDATIONS

## TO THE U.S. GOVERNMENT

The Medicaid funding restrictions imposed by the Hyde Amendment make it extremely difficult for poor women to access abortion services, often forcing them to delay their abortions until the second trimester or, in thousands of cases each year, to continue an unwanted pregnancy. The cost of an abortion ranges from \$413 in the first trimester to roughly three times as much at 20 weeks of pregnancy.<sup>225</sup> In most states, Medicaid covers pregnant women with incomes between 133 and 185% of the federal poverty level—in other words, annual incomes between \$24,352 and \$33,874 for a family of three.<sup>226</sup> At this income level, the costs of arranging for an abortion—which may include not only the cost of the procedure, but also expenses such as transportation, child care, and loss of wages—are significant. Indeed, at least one in four women on Medicaid who wants to have an abortion is forced to continue her pregnancy due to a lack of funds.<sup>227</sup> The Hyde Amendment is, in large part, responsible for poor women's severely limited access to abortion care. The Hyde Amendment undermines a woman's fundamental right to reproductive healthcare and threatens women's overall health and well-being. In addition, the Hyde Amendment discriminates on the basis of gender, race and ethnicity, and socio-economic status, and infringes upon women's rights to autonomy and health.

The Center believes that Medicaid coverage of abortion is critical for women's health and safety and for the realization of their fundamental human rights, and urges the U.S. government to take action as follows:

- Repeal the Hyde Amendment and other restrictions that prohibit federal funding of abortion.
- Guarantee all women, regardless of immigration status, access to the full range of reproductive healthcare services by expanding Medicaid eligibility.<sup>228</sup>

- Include abortion in all government health programs, including those that provide coverage to Native American women using the Indian Health Service, federal prisoners, women in the military, Peace Corps volunteers, disabled women, and federal employees.<sup>229</sup>
- Ratify the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) to demonstrate the United States' commitment to women's equality and right to reproductive healthcare, and take steps to comply with its provisions.

## TO STATE GOVERNMENTS

While the Hyde Amendment limits the use of federal funds for abortion services, except in a narrow set of circumstances, state governments have the option of providing broader coverage under state funding programs ("state Medicaid") using state funds. However, only seventeen states ("non-discrimination states") currently use their own funds to provide coverage for all or most medically necessary abortions.<sup>230</sup> In the vast majority of states ("Hyde states"), Medicaid coverage for abortion is available only in cases of rape, incest, or life endangerment, in line with the restrictions imposed by the Hyde Amendment.<sup>231</sup> Six states ("Hyde-plus states") have slightly expanded that coverage to include abortions in cases of fetal abnormality or endangerment of a pregnant woman's physical health.<sup>232</sup>

In addition, some states are failing to provide Medicaid funds for abortions in cases of rape, incest, or life endangerment, in violation of federal law. In both Hyde states and non-discrimination states it can be extremely burdensome, in practice, for reproductive healthcare providers to obtain or rely upon Medicaid reimbursement for abortion services. It is nearly impossible for some providers to recover their costs for providing abortion to Medicaid patients, both because Medicaid reimbursements are too low and because Medicaid

payments arrive either too late or not at all. The difficulties in obtaining timely or adequate payments through Medicaid have led many abortion providers to elect not to participate in Medicaid, thus presenting yet another factor contributing to the scarcity of abortion services for poor women in the United States. Because it is critical for women's health, safety, and ability to exercise their fundamental human rights for states to expand their Medicaid coverage of reproductive healthcare, the Center urges state and local governments to take action as follows:

### FOR HYDE STATES AND HYDE-PLUS STATES:

- Restore state Medicaid funding for abortion, ensuring that coverage of abortion is offered to the same extent that Medicaid funding is available for pregnancy, prenatal care, and other medical services.
- In the meantime, ensure that state policies allow reproductive healthcare providers to be reimbursed by state Medicaid programs for abortion services to the extent required by law, including in cases of rape, incest, or life endangerment.
- Develop definitions of rape, incest, and life endangerment that do not endanger patient safety and privacy or significantly delay abortions, and make those definitions clear to reproductive healthcare providers and staff administering the state Medicaid program.

### FOR ALL STATES:

- Take concrete steps to improve current procedures for processing Medicaid claims for abortion services to ensure that healthcare providers are able to obtain reimbursement for procedures covered under the state's Medicaid policy. For example, state governments can:
  - educate staff administering the state Medicaid program about state policies on reimbursement for abortion and reproductive healthcare services;
  - establish reasonable documentation require-

ments and educate staff administering the state Medicaid program about what documentation is needed to establish that an abortion is covered by the state Medicaid program;

- designate a point person in the state Medicaid office to help abortion providers when they face obstacles to getting Medicaid reimbursement; and
  - simplify the procedures for submitting claims for reimbursement so that they are in line with reimbursement procedures for other medical services.
- Take concrete steps to ensure that it is financially viable for healthcare providers to treat women enrolled in Medicaid. This must include ensuring a reasonable reimbursement rate for abortion and related medical services that is comparable to reimbursement rates for other types of healthcare and reflects the actual costs of providing abortion services. It should also include facilitating the certification of abortion providers as Medicaid providers.
  - Establish presumptive eligibility for Medicaid in order to ensure that pregnant women can obtain abortions, as well as other critical healthcare, in a timely manner or, for states that already provide for presumptive eligibility, take steps to simplify the current enrollment process.
  - In states where Medicaid enrollment eligibility for pregnant women is below 300% of the federal poverty level, increase eligibility levels to expand Medicaid coverage for pregnant women.

### TO THE UNITED NATIONS SPECIAL RAPORTEURS AND HUMAN RIGHTS BODIES

The Hyde Amendment violates the fundamental human rights of low-income women in the United States by restricting their access to abortion, a medical procedure that is integral to women's reproductive health and autonomy. In addition, the funding restrictions discriminate against women by singling out and excluding from Medicaid coverage, except in the most

extreme circumstances, a medical procedure that only women need, and discriminate against poor women and women of color by undermining their reproductive health choices.<sup>233</sup> Bearing that in mind, the Center urges the United Nations to take action as follows:

- Speak out against restrictions on public funding for reproductive healthcare services, including abortion, as fundamental human rights violations.
- Urge the United States to ratify the Convention on the Elimination of All Forms of Discrimination against Women, one of the key international human rights treaties that guarantees women's right to reproductive healthcare.
- Issue communications, observations, and recommendations to the U.S. government highlighting the importance of including reproductive healthcare in a comprehensive U.S. healthcare program.

## TO NATIONAL ORGANIZATIONS REPRESENTING THE MEDICAL COMMUNITY

The Hyde Amendment restrictions on Medicaid funding for abortion pose substantial obstacles both to women seeking reproductive healthcare services and to healthcare providers working to make those services available. The Center urges national organizations representing the medical community to join in advocating for full public funding for reproductive healthcare services by taking the following actions:

- Adopt resolutions and guidelines supporting the inclusion of reproductive healthcare as an integral part of a comprehensive U.S. healthcare program.
- Follow the recommendations for supporting reproductive justice, set forth below for advocacy organizations and members of the public.

## TO REPRODUCTIVE HEALTHCARE PROVIDERS

Even in cases where federal law requires state Medicaid programs to cover abortion services, poor women

are frequently denied payment. Moreover, because of the low reimbursement rates offered for abortion services, as well as the time and administrative expenses involved in dealing with onerous, ambiguous, and inefficient state Medicaid billing and reimbursement policies and procedures, abortion providers are often reluctant to seek Medicaid reimbursement even in cases where Medicaid payment should be available. While sensitive to the many obstacles and challenges faced by abortion providers, the Center believes it is critical for reproductive healthcare providers to provide access to their services through Medicaid. To that end, the Center urges reproductive healthcare providers in states that provide broad Medicaid coverage for abortion to take action as follows:

- Join national and state efforts to repeal the Hyde Amendment and advocate for the full restoration of Medicaid funding for abortion.
- If possible, become approved Medicaid providers.
- Ensure that staff is kept informed of current state laws and policies regarding Medicaid coverage for reproductive healthcare.
- Educate women about their right to access Medicaid-funded reproductive healthcare in the state.
- To the extent possible, submit claims for reimbursement to state Medicaid offices for all reproductive healthcare services that should be covered by Medicaid in the state and seek to establish relationships with staff to facilitate the processing of claims.
- To the extent possible, if claims for reimbursement are wrongfully denied by the state Medicaid office, work with reproductive justice advocates and attorneys to challenge the denial and clarify state Medicaid policies.
- Seek to establish relationships with staff at the state health department, and work with them and other public officials to remove barriers to Medicaid funding for reproductive healthcare.

- Work with the leadership of state Medicaid programs to assist them in establishing reimbursement rates for abortion services that adequately compensate providers.

## TO ADVOCACY ORGANIZATIONS AND REPRODUCTIVE JUSTICE SUPPORTERS

Restrictions on Medicaid funding for abortion infringe upon women’s fundamental right to access reproductive healthcare and, in practice, force poor women to continue unwanted pregnancies, to delay abortion procedures, and to suffer additional financial strain. Studies have found that poor women are often forced to divert money that they otherwise would have spent on other basic necessities such as rent, utility bills, food, or clothing for themselves or their children, and that some women resort to measures such as pawning household goods, theft, or sex work in order to raise enough money to pay for an abortion.<sup>234</sup>

The Center urges advocacy organizations and the public to join in advocating for full public funding for reproductive healthcare services by taking action as follows:

- Educate the public and policymakers on access to reproductive healthcare as a human right and abortion as an integral part of women’s healthcare.
- Advocate for the repeal of the Hyde Amendment and federal and state laws that impose restrictions on public funding for abortion and reproductive healthcare services.
- Advocate for the inclusion of reproductive healthcare, including abortion, as an integral part of a comprehensive national healthcare program.
- Advocate for higher Medicaid reimbursement rates for reproductive healthcare services, and for more simple and expedient state Medicaid reimbursement procedures.
- Advocate for more simple requirements and more expedient procedures for obtaining

presumptive eligibility for state Medicaid.

- Advocate for expanded Medicaid coverage in states where Medicaid does not cover pregnant women up to an income level of 300% of the federal poverty level.
- Advocate for the United States to ratify CEDAW.

- 1 Ctrs. for Medicare and Medicaid Servs., U.S. Dep't of Health and Hum. Serv., Medicaid Program – General Information, <http://www.cms.hhs.gov/MedicaidGenInfo/> (last visited Jul. 22, 2010) [hereinafter “CMS Overview”].
- 2 KAISER FAM. FOUND., HEALTH REFORM: IMPLICATIONS FOR WOMEN'S ACCESS TO COVERAGE AND CARE 2 (Oct., 2009), <http://www.kff.org/womenshealth/upload/7987.pdf>.
- 3 See Dep't of Labor, Health and Hum. Serv., and Educ. and Related Agencies Appropriations Act, 1998, Pub. L. No. 105-78, §§ 509-510, 111 Stat. 1467(1997).
- 4 An additional twenty-seven percent of women obtaining abortions were low-income, defined as reporting family incomes of below 200 percent of the federal poverty level. RACHEL K. JONES, LAWRENCE B. FINER & SUSHEELA SINGH, GUTTMACHER INST., CHARACTERISTICS OF U.S. ABORTION PATIENTS, 2008 8-9 (May 2010), <http://www.guttmacher.org/pubs/US-Abortion-Patients.pdf>.
- 5 See Ctr. for Disease Control, *Effects of restricting federal funds for abortion—Texas*, MORBIDITY AND MORTALITY WEEKLY REPORT, Jun. 6, 1980, at 253; James Trussell et al., *The Impact of Restricting Medicaid Financing for Abortion*, 12 FAM. PLAN. PERSP. 120 (1980); Aida Torres et al., *Public Benefits and Costs of Government Funding for Abortion*, 18 FAM. PLAN. PERSP. 111, (1986); Rebecca M. Blank et al., *State Abortion Rates: The Impact of Policies, Providers, Politics, Demographics, and Economic Environment*, 15 J. HEALTH ECON. 513 (1996); Philip J. Cook et al., *The Effects of Short-Term Variation in Abortion Funding on Pregnancy Outcomes*, 18 J. HEALTH ECON. 241 (1999); S. Philip Morgan & Allan M. Parnell, *Effects on pregnancy outcomes of changes in the North Carolina state abortion fund*, 21 POPULATION RES. AND POL'Y REV. 319 (2002); STANLEY K. HENSHAW ET AL., GUTTMACHER INST., RESTRICTIONS ON MEDICAID FUNDING FOR ABORTIONS: A LITERATURE REVIEW (Jun., 2009), <http://www.guttmacher.org/pubs/MedicaidLitReview.pdf>.
- 6 Nat'l Network of Abortion Funds, Stop Stupak, <http://www.nnaf.org/stopstupak.html> (last visited Jul. 22, 2010).
- 7 GUTTMACHER INST., FACTS ON INDUCED ABORTION IN THE UNITED STATES 1 (May 2010), [http://www.guttmacher.org/pubs/fb\\_induced\\_abortion.pdf](http://www.guttmacher.org/pubs/fb_induced_abortion.pdf).
- 8 GUTTMACHER INST., TRENDS IN THE CHARACTERISTICS OF WOMEN OBTAINING ABORTIONS 1974-2004 15 (Aug., 2008), <http://www.guttmacher.org/pubs/2008/09/23/TrendsWomenAbortions-wTables.pdf>.
- 9 Jones, Finer, & Singh, *supra* note 4, at 8.
- 10 *Id.* “Poor” is defined as below the federal poverty level, and “low-income” as below 200 percent of poverty.
- 11 See Ctr. for Disease Control, *supra* note 5; Trussell et al., *supra* note 5; Torres et al., *supra* note 5; Blank et al., *supra* note 5; Cook et al., *supra* note 5; Morgan & Parnell, *supra* note 5; Henshaw et al. *supra* note 5.
- 12 Interview with W.S. (Nov. 9, 2009).
- 13 Rachel K. Jones et al., *Abortion in the United States: Incidence and Access to Services*, 40 PERSP. ON SEXUAL AND REPROD. HEALTH 6, 14 (2008), available at <http://www.guttmacher.org/pubs/journals/4000608.pdf>.
- 14 Guttmacher Inst., *supra* note 7, at 2.
- 15 *Id.*
- 16 Heather D. Boonstra, *The Heart of the Matter: Public Funding for Abortion for Poor Women in the United States*, 10 GUTTMACHER POL'Y REV. 12, 14 (2007), available at <http://www.guttmacher.org/pubs/gpr/10/1/gpr100112.pdf>.
- 17 CMS Overview, *supra* note 1.
- 18 One woman interviewed was from a Hyde Plus state. Researchers received 63 referrals from participating clinics and abortion Funds.
- 19 The states that follow Hyde are: Alabama, Arkansas, Colorado, Delaware, Florida, Georgia, Idaho, Kansas, Kentucky, Louisiana, Maine, Michigan, Missouri, Nebraska, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia, and Wyoming. The District of Columbia also followed Hyde at the time participants were recruited for the investigation.
- 20 Eligibility was determined to the best of researchers' ability, relying on information from the woman interviewed and the clinic and/or Fund that assisted her. One of the women interviewed may not have met the income-eligibility cut-off in her state. Both income level and citizenship/immigration status were considered in terms of Medicaid eligibility requirements.
- 21 The Center's collaborators included the clinics that Whole Woman's Health operates in Texas (in Austin, Beaumont, Fort Worth and McAllen); the Philadelphia Women's Center in Philadelphia, Pennsylvania; the three clinics that Northland Family Planning Centers operates in the Detroit, Michigan area; the Feminist Women's Health Center in Atlanta, Georgia; and the Hope Medical Group for Women in Shreveport, Louisiana.
- 22 The Center sought clinics that were located in one of the Hyde

- states; had the capacity and willingness to participate; had sufficient patient volume to generate two to three interviews during the designated period; gathered relevant information about women, including Medicaid eligibility or likely eligibility; counseled and assisted women in obtaining abortion funding; and offered domestic violence counseling or referrals for women reporting abuse.
- 23 Interviews were conducted with the Executive Directors of the Chicago Abortion Fund in Chicago, Illinois and the Women’s Medical Fund in Philadelphia, Pennsylvania, and with the Program Manager for ACCESS/Women’s Health Rights Coalition in Oakland, California.
- 24 Telephone Interview with Susan Schewel, Executive Director, Women’s Medical Fund, in Philadelphia, PA (Jan. 26, 2010).
- 25 In 2008, thirteen percent of women who obtained abortions received financial assistance from abortion Funds and/or fee reductions from clinics. Jones, Finer, & Singh, *supra* note 4, at 11.
- 26 Jones, Finer, & Singh, *supra* note 4, at 12-13; Nat’l Network of Abortion Funds, *About Abortion Funds*, <http://www.nnaf.org/aboutfunds.html> (last visited Jul. 23, 2010).
- 27 Telephone Interview with Lisa Banh, Program Manager, ACCESS/Women’s Health Rights Coalition, in Oakland, CA (Jan. 27, 2010).
- 28 Telephone Interview with Stephanie Poggi, Executive Director, National Network of Abortion Funds, in Boston, MA (May 27, 2010).
- 29 Jones, Finer, & Singh, *supra* note 4, at 12.
- 30 Researchers interviewed three providers in non-discrimination states, including a provider in West Virginia, the Executive Director of Whole Woman’s Health in Baltimore, Maryland, and the former Executive Director of Aradia Women’s Health Center in Seattle, Washington, which closed in 2007.
- 31 Women using a cell phone were told beforehand that they would receive a one-hour phone card to reimburse them for their minutes. After the interview, women learned that they would receive a \$25 gift card. Providers, clinic staff members, and abortion Fund representatives did not receive payment for their participation.
- 32 *Harris v. McRae*, 448 U.S. 297, 330 (1981), Brennan, J. dissenting.
- 33 The federal Medicaid program was created by Title XIX of the Social Security Act under the Amendments of 1965, 42 U.S.C. §§ 1396-1396v (1994 & Supp. II 1996).
- 34 CMS Overview, *supra* note 1.
- 35 *Id.*
- 36 VERNON K. SMITH ET AL., KAISER COMMISSION ON MEDICAID AND THE UNINSURED, THE CRUNCH CONTINUES: MEDICAID SPENDING, COVERAGE AND POLICY IN THE MIDST OF A RECESSION 5 (2009), <http://www.kff.org/medicaid/upload/7985.pdf>.
- 37 KAISER FAM. FOUND., HEALTH REFORM: IMPLICATIONS FOR WOMEN’S ACCESS TO COVERAGE AND CARE 2 (Oct. 2009), <http://www.kff.org/womenshealth/upload/7987.pdf>.
- 38 KAISER FAM. FOUND. & GUTTMACHER INST., WOMEN’S ISSUE BRIEF: MEDICAID’S ROLE IN FAMILY PLANNING 1 (Oct. 2007), [http://www.kff.org/womenshealth/upload/7064\\_03.pdf](http://www.kff.org/womenshealth/upload/7064_03.pdf).
- 39 USHA RANJI & ALINA SALGANICOFF, KAISER FAMILY FOUND., STATE MEDICAID COVERAGE OF PERINATAL SERVICES: SUMMARY OF STATE SURVEY FINDINGS I (Nov., 2009), <http://www.kff.org/womenshealth/upload/8014.pdf>.
- 40 42 U.S.C. §1396(a)(10)(A)(i) & (ii). For details on state eligibility levels, see KAISER FAMILY FOUND., WHERE ARE STATES TODAY? MEDICAID AND STATE-FUNDED COVERAGE ELIGIBILITY LEVELS FOR LOW-INCOME ADULTS (Dec., 2009), <http://www.kff.org/medicaid/upload/7993.pdf>.
- 41 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §2001(a)(1)(C), 124 Stat. 129 (2010). States can begin Medicaid expansions now and all expansions will be in place by 2014.
- 42 NAT’L NETWORK OF ABORTION FUNDS, ABORTION FUNDING: A MATTER OF JUSTICE POLICY REPORT 5 (2005), <http://www.nnaf.org/pdf/NNAF%20Policy%20Report.pdf>. This policy report details the circumstances and experiences of women seeking support from abortion Funds and presents policy recommendations to ensure that every woman has the opportunity to make her own best decision and care for herself and her family. See Personal Responsibility and Work Opportunity Act, Pub. L. No. 104-193, 110 Stat. 2105 (1996), available at [http://www.fns.usda.gov/snap/rules/Legislation/pdfs/PL\\_104-193.pdf](http://www.fns.usda.gov/snap/rules/Legislation/pdfs/PL_104-193.pdf).
- 43 Personal Responsibility and Work Opportunity Act §2001(a)(1)(C), *supra* note 41.
- 44 Nine states did so, as of 2003. Rachel Benson Gold, *Immigrants and Medicaid After Welfare Reform*, 6 GUTTMACHER REP. ON PUB. POL’Y 6, 6 (May 2003), available at <http://www.guttmacher.org/pubs/tgr/06/2/gr060206.pdf>. See also Nat’l Network of Abortion Funds, *supra*

- note 42, at 5.
- 45 LEIGHTON KU, *CTR. ON BUDGET & POLICY PRIORITIES, REDUCING DISPARITIES IN HEALTH COVERAGE FOR LEGAL IMMIGRANT CHILDREN AND PREGNANT WOMEN 2* (Apr., 2007), <http://www.cbpp.org/files/4-20-07health2.pdf>. As of 2006, less than half of states provided Medicaid or SCHIP coverage. *Id.* The 2009 reauthorization of CHIP reinstated the use of federal funding for states that elect this option, effective April 1, 2009. NAT'L IMMIGR. LAW CTR., *FACTS ABOUT NEW STATE OPTION TO PROVIDE HEALTH COVERAGE TO IMMIGRANT CHILDREN AND PREGNANT WOMEN 1* (Apr., 2009), <http://www.nilc.org/immspbs/cdev/ICHIA/ICHIA-facts-2009-04-01.pdf>.
- 46 Kaiser Fam. Found., *Income Eligibility Levels for Pregnant women by Annual Income as a percent of Federal Poverty Level (FPL) as of Dec. 2009*, <http://www.statehealthfacts.org/comparable.jsp?ind=206&cat=4> (last visited Jul. 23, 2010).
- 47 The 2009 poverty guidelines are in effect until the 2010 guidelines are published in the Federal Register. Assistant Sec'y for Plan. and Eval., Dep't of Health and Hum. Serv., *The 2009 HHS Poverty Guidelines: One Version of the U.S. Federal Poverty Measure*, <http://aspe.hhs.gov/poverty/09poverty.shtml> (last visited Jul. 23, 2010).
- 48 Ranji & Salganicoff, *supra* note 39, at 3.
- 49 *Id.* at 4.
- 50 Ctr. for Reprod. Rts., *Portrait of Injustice: Abortion Coverage under the Medicaid Program* (May 1, 2004), <http://reproductiverights.org/en/document/portrait-of-injustice-abortion-coverage-under-the-medicaid-program> (last visited Jul. 26, 2010).
- 51 See Dep't of Labor, Health and Hum. Serv., and Educ. and Related Agencies Appropriations Act, 1998, Pub. L. No. 105-78, §§ 509-510, 111 Stat 1467 (1997).
- 52 *Harris*, 448 U.S. at 326-27.
- 53 *Id.* at 331 (Brennan, J., dissenting).
- 54 *Id.* at 344 (Marshall, J., dissenting).
- 55 See INT'L PLANNED PARENTHOOD FOUND., *ABORTION LEGISLATION IN EUROPE* (Jan., 2007), [http://www.ippfen.org/NR/rdonlyres/2EB28750-BA71-43F8-AE2A-8B55A275F86C/0/Abortion\\_legislation\\_Europe\\_Jan2007.pdf](http://www.ippfen.org/NR/rdonlyres/2EB28750-BA71-43F8-AE2A-8B55A275F86C/0/Abortion_legislation_Europe_Jan2007.pdf). See also Tit Albrecht et al., *European Observatory on Health Systems and Policies*, 11 SLOVN. HEALTH SYS. REV. 1, 51 (2009), available at <http://www.euro.who.int/document/e92607.pdf>. Belgium (reimbursement for abortions performed in clinics that have an agreement with the national institute of social security); Bulgaria (free abortions on medical grounds and in certain other instances); Cyprus (free hospital abortions for patients eligible for free medical care); Czech Republic (free abortions on medical grounds); Denmark (abortions are part of public health system); Finland (abortion free under national health insurance); France (full reimbursement for poor women and women under 18); Germany (full coverage on medical and other grounds under statutory health and civil service health insurance); Greece (free hospital abortions); Hungary (abortions on medical grounds covered under Health Insurance Fund, additional coverage on other grounds); Italy (abortions free of charge for all women); Lithuania (abortions for medical indications covered under Compulsory Health Insurance Fund); Luxembourg (abortions reimbursed by National Health Insurance); Moldova (insurance system covers abortions for social and medical indications); Netherlands (reimbursement for abortions); Poland (legal abortions covered by State Health Care system); Romania (free of charge for women in difficult socio-economic conditions); Slovak Republic (free of charge on medical grounds); Spain (abortions free of charge, covered by public health insurance); Sweden (cost almost fully covered by National Health Insurance); United Kingdom (in principle free of charge on National Health Service); Slovenia (reimbursement under national health law system).
- 56 Int'l Planned Parenthood Found., *supra* note 55. Iceland (abortions free of charge under National Health Insurance); Israel (abortions free of charge on medical grounds and for women under 18); Macedonia (obligatory health insurance will cover abortions if proven to harm the health of the woman); Norway (abortions free of charge); Russian Federation (abortions performed within compulsory health insurance program free of charge); Switzerland (health insurance covers lawful termination under the same terms as illness).
- 57 Nat'l Abortion Fed'n., *Access to Abortion in Canada*, <http://www.prochoice.org/canada/regional.html> (last visited Jul. 26, 2010). All plans cover abortion, but the accessibility of abortion services as well as the terms of coverage vary from province to province. See Joanna N. Erdmann, *In the Back Alleys of Health Care: Abortion Equality, and Community in Canada*, 56 EMORY L. J. 1093, 1094-95 (2007) (discussing how provincial regulations limiting coverage to abortions performed in public hospitals coupled with the shortage of hospitals providing abortion services has resulted in a significant barrier to women in need of abortion funding).
- 58 *Jane Doe I v. Manitoba*, [2004] 248 D.L.R.(4th) 547 (Man. Q.B.); rev'd [2005] 260 D.L.R.

- (4th) 149 (Man. C.A.); leave to appeal to S.C.C. refused, [2005] S.C.C.A. No. 513 (Can.). The court granted summary judgment but was overturned by the Court of Appeals on procedural grounds. Before the case was resolved, the provincial government decided it would fund clinic services. Erdmann, *supra* note 57, at 1098. A case challenging a similar regulation in New Brunswick is still pending. Erdmann, *supra* note 57, at 1097.
- 59 *Abortion Legalized in Mexico*, BBC NEWS, April 25, 2007, available at <http://news.bbc.co.uk/2/hi/americas/6586959.stm>.
- 60 Elisabeth Malkin, *Mexico City Struggles with Law on Abortion*, N.Y. TIMES, Aug. 24, 2008, available at <http://www.nytimes.com/2008/08/25/world/americas/25mexico.html>.
- 61 Press Release, Ctr. for Reprod. Rts., Court Orders Nepal to Improve Access to Abortion (May 20, 2009) (on file with author), available at <http://reproductiverights.org/en/press-room/court-orders-nepal-to-improve-women%E2%80%99s-access-to-abortion>; Legal Code (Eleventh Amendment) Act, Sept. 26 2002 (Nepal), available at <http://www.hsph.harvard.edu/population/abortion/NEPAL.abo.htm>.
- 62 Ctr. for Reprod. Rts., *supra* note 61.
- 63 Choice on Termination of Pregnancy Act 92 of 1996 (S. Afr.), available at <http://www.info.gov.za/gazette/acts/1996/a92-96.htm> (last visited Jul. 26, 2010); South African Dep't of Health, Choice on Termination of Pregnancy (Jan. 28, 1997), available at <http://www.doh.gov.za/docs/pr/1997/pr0128a.html>.
- 64 The District of Columbia policy was deleted in the current federal budget. Until a new policy came into effect, the District only funded abortions that met the Hyde restrictions. See GUTTMACHER INST., STATE POLICIES IN BRIEF AS OF AUGUST 1, 2010: STATE FUNDING FOR ABORTION UNDER MEDICAID 2 (Aug. 1, 2010), [http://www.guttmacher.org/statecenter/spibs/spib\\_SFAM.pdf](http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf). The new policy took effect August 1, 2010.
- 65 *Id.*
- 66 *Women of Minn. v. Gomez*, 542 N.W.2d 17, 31 (Minn. 1995) (stating “[i]t is critical to note that the right of privacy under our constitution protects not simply the right to an abortion, but rather it protects the woman’s decision to abort; any legislation infringing on the decision-making process, then, violates this fundamental right.”); *Comm. to Defend Reprod. Rts. v. Myers*, 625 P.2d 779, 798 (Cal. 1981) (“each woman in this state – rich or poor – is guaranteed the constitutional right to make [the abortion] decision as an individual, uncoerced by governmental intrusion.”).
- 67 *Simat Corp. v. Ariz. Health Care Cost Containment Sys.*, 56 P.3d 28, 31-32 (Ariz. 2002); *Dep’t of Health & Soc. Servs. v. Planned Parenthood of Alaska*, 28 P.3d 904, 910 (Alaska 2001); *Right to Choose v. Byrne*, 450 A.2d 925, 936 (N.J. 1982). The New Mexico Supreme Court held that the Hyde Amendment’s funding restrictions violate the state’s Equal Rights Amendment. *New Mexico Right to Choose/NARAL v. Johnson*, 975 P.2d 841, 859 (N.M. 1998).
- 68 Guttenmacher Inst., *supra* note 64, at 2.
- 69 Telephone interview with Terry Sallas Merritt, Vice President, Whole Woman’s Health, in Austin, TX (Dec. 7, 2009).
- 70 Jones et al., *supra* note 13, at 24.
- 71 Interview with anonymous staff member at Northland Fam. Plan. Ctrs. (Nov. 11, 2009); telephone interview with Kathaleen Pittman, Patient Services Manager, Hope Med. Group for Women, in Shreveport, LA (Nov. 18, 2009).
- 72 Telephone interview with Robin Gelberg, Director of Counseling/Special Needs and Funding Coordinator, Feminist Women’s Health Ctr., in Atlanta, GA (Dec. 15, 2009).
- 73 Interview with Pittman, *supra* note 71.
- 74 Interview with Elizabeth Barnes, Executive Director, Philadelphia Women’s Ctr., in Philadelphia, PA (Feb. 8, 2010).
- 75 Interview with Schewel, *supra* note 24.
- 76 *Id.*
- 77 *Id.*
- 78 Nat’l Network of Abortion Funds, *supra* note 42, at 8.
- 79 Interview with anonymous staff member, *supra* note 71.
- 80 Interview with R.D. (Oct. 5, 2009).
- 81 Interview with anonymous staff member, *supra* note 71.
- 82 *Id.*
- 83 Interview with R.L. (Nov. 2, 2009).
- 84 *Id.*
- 85 Interview with Schewel, *supra* note 24.
- 86 Interview with R.L., *supra* note 83.
- 87 *Id.*
- 88 Interview with C.M. (Oct. 15, 2009).
- 89 Interview with H.S. (Oct. 19, 2009).
- 90 Interview with T.S. (Oct. 19, 2009).
- 91 Interview with S.H. (Oct. 7, 2009).
- 92 Telephone interview with Gaylon Alcaraz, Executive Director, Chicago Abortion Fund, in Chicago, IL (Jan. 26, 2010).
- 93 Boonstra, *supra* note 16, at 14.
- 94 *Id.*; Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 CONTRACEPTION 334, 343 (2006). See also A. Torres and J.D. Forrest, *Why do women have abortions?*, 20 FAM. PLAN. PERSP. 169, 174 (1988).
- 95 Finer et al., *supra* note 94, at 341.

- 96 GUTTMACHER INST., AN OVERVIEW OF ABORTION IN THE UNITED STATES 16 (Oct. 2009), [http://www.guttmacher.org/presentations/abort\\_slides.pdf](http://www.guttmacher.org/presentations/abort_slides.pdf).
- 97 One woman did not respond.
- 98 Interview with Gelberg, *supra* note 72.
- 99 Interview with Schewel, *supra* note 24.
- 100 *Id.*
- 101 *Id.*
- 102 Interview with Alcaraz, *supra* note 92.
- 103 *Id.*
- 104 CTR. FOR REPROD. RTS., DEFENDING HUMAN RIGHTS: ABORTION PROVIDERS FACING THREATS, RESTRICTIONS, AND HARASSMENT 37 (2009), <http://reproductiverights.org/sites/crr.civicactions.net/files/documents/DefendingHumanRights.pdf>.
- 105 *Id.* at 46.
- 106 Interview with C.M., *supra* note 88.
- 107 *Id.*
- 108 Interview with L.Y. (Nov. 16, 2009).
- 109 Interview with R.D., *supra* note 80.
- 110 Interview with M.C. (Nov. 3, 2009).
- 111 Stanley K. Henshaw & Lynn S. Wallisch, *The Medicaid Cutoff and Abortion Services for the Poor*, 16 FAM. PLAN. PERSP. 170, 171 (1984). Of the 59 percent of women who reported experiencing a delay in obtaining an abortion, 26 percent said the delay was caused by needing to raise money for the procedure. Torres & Forrest, *supra* note 93, at 341 (finding that the time needed to raise money for an abortion is an important cause of delay).
- 112 Heather Boonstra & Adam Sonfield, *Rights Without Access: Revisiting Public Funding of Abortion for Poor Women*, 3 GUTTMACHER REP. ON PUBLIC POL'Y 8, 10 (2000), available at <http://www.guttmacher.org/pubs/tgr/03/2/gr030208.pdf>.
- 113 Interview with S.H., *supra* note 91.
- 114 Interview with Schewel, *supra* note 24.
- 115 Interview with Merritt, *supra* note 69.
- 116 *Id.*
- 117 *Id.*
- 118 Interview with T.D. (Oct. 28, 2009). T.D. was from Wisconsin.
- 119 Interview with E.J. (Nov. 3, 2009).
- 120 Interview with Alcaraz, *supra* note 92.
- 121 *Id.*
- 122 Interview with Merritt, *supra* note 69.
- 123 Interview with W.S., *supra* note 12.
- 124 Interview with Poggi, *supra* note 28.
- 125 *Id.*
- 126 *Id.*
- 127 *Id.* This figure is likely quite conservative, because some Funds only reported the number of women helped with funding rather than the number of calls received, and because some Funds only open their phone lines for a limited time each week.
- 128 GUTTMACHER INST., A REAL LOOK AT THE IMPACT OF THE RECESSION ON WOMEN'S FAMILY PLANNING AND PREGNANCY DECISIONS 3 (Sept. 2009), <http://www.guttmacher.org/pubs/RecessionFP.pdf>.
- 129 *Id.* at 5.
- 130 This increase reflected a 25 percent increase in poverty among women of reproductive age in the general population during that time period. Jones, Finer, & Singh, *supra* note 4, at 25.
- 131 Low-income women had abortions at three times the rate of better-off women. *Id.* at 9.
- 132 Interview with H.T. (Nov. 9, 2009).
- 133 Interview with T.S., *supra* note 90.
- 134 Interview with H.S., *supra* note 89.
- 135 Henshaw et al., *supra* note 5, at 27.
- 136 *Id.* See also Heather Boonstra & Adam Sonfield, *supra* note 112, at 10; Blank et al., *supra* note 5, at 536 (using data on abortion rates from 1974-1988, concluding that 19 -25% of abortions among low-income women that are publicly funded do not take place after funding is eliminated); Trussell et al, *supra* note 5, at 127 (18-23% of women in Georgia and Ohio continued their pregnancies without public funding); Ctr. for Disease Control, *supra* note 5, at 255 (35% of women in Texas continued their pregnancies in the absence of public funding).
- 137 Philip J. Cook et al., *supra* note 5.
- 138 *Id.* at 255.
- 139 Interview with Alcaraz, *supra* note 92.
- 140 Interview with Pittman, *supra* note 71.
- 141 Interview with Merritt, *supra* note 69.
- 142 *Id.*
- 143 *Id.*
- 144 Interview with Pittman, *supra* note, 71.
- 145 Interview with T.S., *supra* note 90.
- 146 Torres et al., *supra* note 5, at 116-17.
- 147 *Id.* at 117.
- 148 *Id.*
- 149 See GUTTMACHER INST., ISSUES IN BRIEF: THE COST IMPLICATIONS OF INCLUDING ABORTION COVERAGE UNDER MEDICAID (New York: AGI, 1993).
- 150 A third woman reported being in a long-term abusive relationship and may have been raped.
- 151 ADAM SONFIELD, CASEY ALRICH & RACHEL BENSON GOLD, PUBLIC FUNDING FOR FAMILY PLANNING, STERILIZATION AND ABORTION SERVICES, FY 1980-2006 (OCCASIONAL REPORT No. 38) 27 (2008), <http://www.guttmacher.org/pubs/tgr/03/2/gr030208.pdf>.

- 152 *Id.*
- 153 Out of a total of 191 federally-funded abortions. *Id.*
- 154 Deborah Kacanek et al., *Medicaid Funding for Abortion: Providers' Experiences with Cases Involving Rape Incest and Life Endangerment*, 42 PERSP. ON SEXUAL & REPROD. HEALTH 79, 80 (2010). The six states are Idaho, Kansas, Kentucky, Florida, Pennsylvania, and Wyoming. It is notable that, even in the state where 97% of reimbursements took place, twenty-seven qualifying abortions, out of a total of 126 abortions, were not reimbursed. (The state was not identified in the study to protect the identities of provider representatives.) *Id.*
- 155 *Id.* at 81-83.
- 156 *Id.* at 81.
- 157 *Id.* at 83.
- 158 Interview with Pittman, *supra* note 71. Waiting for Medicaid approval before having the abortion also delays the timely presentation of physical evidence of rape or incest to the police, for victims willing to report to law enforcement.
- 159 *Id.*
- 160 Interview with Barnes, *supra* note 74.
- 161 *Id.*
- 162 See NAT'L NETWORK OF ABORTION FUNDS, TAKIN' IT TO THE STATES: A TOOLKIT FOR EXPANDING ABORTION ACCESS AND REPRODUCTIVE JUSTICE IN YOUR STATE (2008), <http://www.nnaf.org/documents/NationalNetwork--StateAdvocacyToolkit.pdf>.
- 163 Sonfield et al., *supra*, note 151, at 6.
- 164 Jones, Finer, & Singh, *supra* note 4, at 11.
- 165 *Id.*
- 166 Telephone interview with Margaret Johnston, President, The Abortion Care Network, in Washington D.C. (Sept. 18, 2009).
- 167 Telephone interview with Marcy Bloom, former Executive Director, Aradia Women's Health Center (now closed), in Seattle, WA (Jan. 15, 2010).
- 168 *Women of Minn.*, 542 N.W.2d at 31 ("We simply cannot say that an indigent woman's decision whether to terminate her pregnancy is not significantly impacted by the state's offer of comprehensive medical services if the woman carries the pregnancy to term. We conclude, therefore, that these statutes constitute an infringement on the fundamental right to privacy.").
- 169 *Women's Health Ctr. of W.Va. v. Panepinto*, 446 S.E.2d 658, 666 (W. Va. 1993). *See also Moe v. Sec'y of Admin. & Fin.*, 417 N.E.2d 388, 402 (Mass. 1981) ("[O]nce [the legislature] chooses to enter the constitutionally protected area of choice, it must do so with genuine indifference. It may not weight the options open to the pregnant woman by its allocation of public funds; in this area, government is not free to 'achieve with carrots what [it] is forbidden to achieve with sticks.'"), quoting L. Tribe, *American Constitutional Law*, § 15-10 n. 77 (1<sup>st</sup> ed. 1978); *Simat*, 56 P.3d at 32 ("Having undertaken to provide medically necessary health care for the indigent, the state must do so in a neutral manner."); *Planned Parenthood of Alaska*, 28 P.3d at 913 ("[A] woman who carries her pregnancy to term and a woman who terminates her pregnancy exercise the same fundamental right to reproductive choice. Alaska's equal protection clause does not permit governmental discrimination against either woman; both must be granted access to state health care under the same terms as any similarly situated person.").
- 170 *Comm. to Defend Reprod. Rts.*, 625 P.2d at 790. *Cf. Id.* at 799 ("[T]he statutory scheme... is all the more invidious because its practical effect is to deny to poor women the right of choice guaranteed to the rich.").
- 171 *Comm. to Defend Reprod. Rts.*, 625 P.2d at 790. *Cf. Id.* at 799 ("[T]he statutory scheme... is all the more invidious because its practical effect is to deny to poor women the right of choice guaranteed to the rich.").
- 172 *Roe v. Wade*, 410 U.S. 113 (1973).
- 173 *Comm. to Defend Reprod. Rts.*, 625 P.2d at 797. *See also Id.* at 793 ("[T]he state's discriminatory treatment will prevent the vast majority of poor women from exercising their fundamental right to choose whether or not to bear a child."); *Women of Minnesota v. Gomez*, 542 N.W.2d at 19 (finding broader protection to women's privacy right under state constitution than under U.S. Constitution, and thus rejecting *Harris v. McRae*).
- 174 *Comm. to Defend Reprod. Rts.*, 625 P.2d at 797.
- 175 New York State Dep't of Health, Presumptive Eligibility Qualified Provider Application, [http://www.health.state.ny.us/health\\_care/medicaid/program/docs/qualified\\_provider.pdf](http://www.health.state.ny.us/health_care/medicaid/program/docs/qualified_provider.pdf) (last visited Jul. 26, 2010).
- 176 *Id.*
- 177 *See* New York State Dep't of Health, What Health Services are Covered by Medicaid?, [http://www.health.state.ny.us/health\\_care/medicaid/#services](http://www.health.state.ny.us/health_care/medicaid/#services) (last visited Jul. 26, 2010).
- 178 Nat'l Inst. For Reprod. Health, Resource Guide for New York State Abortion Providers: Helping Low-Income Women Pay for Abortions in New York State, <http://www.nirhealth.org/sections/ourprograms/documents/>

- ProviderResourceGuidefinal.pdf (last visited Jul. 26, 2010).
- 179 Interview with Bloom, *supra* note 167.
- 180 Interview with an anonymous West Virginia provider (Feb. 3, 2010).
- 181 ACCESS/WOMEN'S HEALTH RTS. COAL., BARRIERS TO ENTRY: ENSURING EQUITABLE AND TIMELY ACCESS TO MEDI-CAL FOR PREGNANT WOMEN 1 (March 2009), [http://www.whrc-access.org/pdf/MediCal\\_Brief\\_4.pdf](http://www.whrc-access.org/pdf/MediCal_Brief_4.pdf).
- 182 ACCESS/Women's Health Rts. Coal., Medi-Cal Reimbursement for Second Trimester Abortion, [http://www.whrc-access.org/pdf/Access-Medi-Cal\\_Reimbursement\\_for\\_Second\\_Tri\\_Abortion.pdf](http://www.whrc-access.org/pdf/Access-Medi-Cal_Reimbursement_for_Second_Tri_Abortion.pdf) (last visited Jul. 26, 2010).
- 183 Interview with Banh, *supra* note 27.
- 184 *Id.*
- 185 *Id.*
- 186 Telephone interview with Gloria Johnson, Executive Director, Whole Woman's Health, in Baltimore, MD (Jan. 6, 2010).
- 187 *Id.*
- 188 *Id.*
- 189 Other non-discrimination states, such as California, permit electronic filing of abortion claims, but require all of the supplemental paperwork to be submitted by mail. Telephone interview with Destiny Lopez, former Executive Director, ACCESS/Women's Health Rts. Coal., in Oakland, CA (Nov. 28, 2009).
- 190 Interview with an anonymous West Virginia provider, *supra* note 180.
- 191 *Id.*
- 192 Interview with Johnson, *supra* note 186. This is also the case in California. Interview with Lopez, *supra* note 189.
- 193 Interview with Bloom, *supra* note 167.
- 194 *Id.*
- 195 Interview with Johnson, *supra* note 186.
- 196 Interview with Schewel, *supra* note 24.
- 197 International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, G.A. res. 2200A (XXI), U.N. GAOR 21st Sess., Supp. No. 16, arts 2.1, 6.1, 17, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) [hereinafter ICCPR]; International Convention on the Elimination of All Forms of Racial Discrimination, *adopted* Dec. 21, 1965, G.A. res. 2106 (XX), art 5(e)(iv)(1965), U.N. Doc. A/6014 (1966), 660 U.N.T.S. 195 (*entered into force* Jan. 4, 1969) [hereinafter CERD]; Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, arts. 1, 10, 12, U.N. Doc. A/34/46 (1979), 1249 U.N.T.S. 12 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW]; International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, G.A. res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, arts. 2(2), 12, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3 (*entered into force* Jan. 3, 1976) [hereinafter ICESCR]; *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, Principle 8 and ¶ 7.2, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter ICPD *Programme of Action*]; *Beijing Declaration and the Platform for Action, Fourth World Conference on Women*, Beijing, China, Sept. 4-15 1995, ¶¶ 89-92, U.N. Doc. A/CONF.177/20 (1996) [hereinafter *Beijing Declaration and Platform for Action*]; *Vienna Declaration and Programme of Action, World Conference on Human Rights*, Vienna, Austria, Jun 14-25, 1993, ¶ 18, U.N. Doc. A/CONF.157/23 (1993).
- 198 ICCPR, *supra* note 197, at arts. 2, 6, 17, 26. The ICCPR was ratified by the U.S. in 1992.
- 199 CERD, *supra* note 197, at arts. 2, 5. CERD was ratified by the U.S. in 1994.
- 200 Human Rights Committee, *General Comment 31, Nature of the General Legal Obligation on States Parties to the Covenant*, paras. 3-6, (18<sup>th</sup> Sess., 2004) U.N. Doc. CCPR/C/21/Rev.1/Add.13 (2004); Human Rights Committee, *General Comment 3, Article 2 Implementation at the national level*, para. 1, (13<sup>th</sup> Sess., 1981), U.N. Doc. HRI/GEN/1/Rev.1 at 4 (1994) [hereinafter HRC, *General Comment 3*]. CERD, *supra* note 197, at art. 2 (“States Parties . . . undertake to pursue by all appropriate means and without delay a policy of eliminating racial discrimination in all its forms.”).
- 201 HRC, *General Comment 3, supra* note 200, at ¶ 1 (“The Committee considers it necessary to draw the attention of States parties to the fact that the obligation under the Covenant is not confined to the respect of human rights, but that States parties have also undertaken to ensure the enjoyment of these rights to all individuals under their jurisdiction. This aspect calls for specific activities by the States parties to enable individuals to enjoy their rights.”).
- 202 The U.S. has signed, but not ratified, the ICESCR.
- 203 The U.S. has signed, but not ratified, the CEDAW.
- 204 Vienna Convention on the Law of Treaties, art. 18, 1155 U.N.T.S. 331, U.S. No. 58 (1980), *reprinted in* 8 I.L.M. 679 (1969) (*entered into force* Jan. 27, 1980).
- 205 *See, e.g., Concluding Observations of the Committee on the Elimination of Discrimination against Women: Andorra, 25<sup>th</sup> Sess., 516 -523<sup>rd</sup> mtg., para.*

48, U.N. Doc. A/56/38 (2001); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Antigua and Barbuda*, 17<sup>th</sup> Sess., 340-348<sup>th</sup> mtg., para. 258, U.N. Doc. A/52/38/Rev.1, Part II (1997); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Belize*, 20<sup>th</sup> Sess., 432-438<sup>th</sup> mtg., para. 56, U.N. Doc. A/54/38 (1999); *Bolivia*, 14<sup>th</sup> Sess., 284<sup>th</sup> mtg., para. 82, U.N. Doc. A/50/38 (1995); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Chile*, 14<sup>th</sup> Sess., 264-271<sup>st</sup> mtg., para. 139, U.N. Doc. A/50/38 (1995); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Chile*, 36<sup>th</sup> Sess., 749-750<sup>th</sup> mtg., para. 19, U.N. Doc. CEDAW/C/CHI/CO/4 (2006); *Colombia*, 20-21<sup>st</sup> Sess., 424<sup>th</sup> mtg., para. 393, U.N. Doc. A/54/38 (1999); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Cyprus*, 15<sup>th</sup> Sess., 287<sup>th</sup> mtg., para. 55, U.N. Doc. A/51/38 (1996); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Dominican Republic*, 18-19<sup>th</sup> Sess., 379-380<sup>th</sup> mtg., para. 337, U.N. Doc. A/53/38 (1998); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Ireland*, 20<sup>th</sup> Sess., 440-441<sup>st</sup> mtg., para. 185, U.N. Doc. A/54/38 (1999); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Jordan*, 22<sup>nd</sup> Sess., 448-456 mtg., para. 180, U.N. Doc. A/55/38 (2000); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Liechtenstein*, 20<sup>th</sup> Sess., 410-414<sup>th</sup> mtg., para. 169, U.N. Doc. A/54/38 (1999); *Concluding Observations of the Committee on*

*the Elimination of Discrimination against Women: Luxembourg*, 16-17<sup>th</sup> Sess., 338-344<sup>th</sup> mtg., para. 210, U.N. Doc. A/52/38/Rev.1, Part II (1997); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Mauritius*, 14<sup>th</sup> Sess., 268-271<sup>st</sup> mtg., para. 196, U.N. Doc. A/50/38 (1995); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Mauritius*, 36<sup>th</sup> Sess., 745-746 mtg., para. 30, U.N. Doc. CEDAW/C/MAR/CO/5 (2006); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Namibia*, 16-17<sup>th</sup> Sess., 336-342 mtg., para. 111, U.N. Doc. A/52/38/Rev.1, Part II (1997); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Nepal*, 20<sup>th</sup> Sess., 343-349<sup>th</sup> mtg., paras. 139, 147, U.N. Doc. A/54/38 (1999); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Panama*, 18-19<sup>th</sup> Sess., 392-393<sup>rd</sup> mtg., para. 201, U.N. Doc. A/53/38/Rev.1 (1998); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Paraguay*, 15<sup>th</sup> Sess., 289 & 297<sup>th</sup> mtg., para. 131, U.N. Doc. A/51/38 (1996); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Peru*, 18-19<sup>th</sup> Sess., 397-398<sup>th</sup> mtg., para. 339, U.N. Doc. A/53/38/Rev.1 (1998); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Portugal*, 26<sup>th</sup> Sess., 534-535<sup>th</sup> mtg., para. 345, A/57/38 (2002); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Saint Vincent and the Grenadines*, 16-17<sup>th</sup> Sess., 317&322<sup>nd</sup> mtg., para. 140, U.N. Doc. A/52/38/Rev.1 (1997); *Concluding Observations of the*

*Committee on the Elimination of Discrimination against Women: Suriname*, 37<sup>th</sup> Sess., 769-770<sup>th</sup> mtg., para. 29, U.N. Doc. CEDAW/C/SUR/CO/3 (2007); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: United Kingdom of Great Britain and Northern Ireland*, 20- 21<sup>st</sup> Sess., 424<sup>th</sup> mtg., para. 309, U.N. Doc. A/55/38 (1999); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Venezuela*, 16-17<sup>th</sup> Sess., 333<sup>rd</sup> mtg., para. 236, U.N. Doc. A/52/38/Rev.1 (1997); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Zimbabwe*, 18-19<sup>th</sup> Sess., 383<sup>rd</sup> mtg., para. 159, U.N. Doc. A/53/38 (1998); *Concluding Observations of the Human Rights Committee: Chile*, 89<sup>th</sup> Sess., 2429- 2430<sup>th</sup> mtg., para. 8, U.N. Doc. CCPR/C/CHL/CO/5 (2007); *Concluding Observations of the Human Rights Committee: Madagascar*, 89<sup>th</sup> Sess., 2425-2426<sup>th</sup> mth., para. 14, U.N. Doc. CCPR/C/MDG/CO/3 (2007); *Concluding Observations of the Human Rights Committee: Bolivia*, 59<sup>th</sup> Sess., 1562-1563<sup>rd</sup> mtg., para/ 22, U.N. Doc. CCPR/C/79/Add.74 (1997); *Concluding Observations of the Human Rights Committee: Chile*, 65<sup>th</sup> Sess., 1740<sup>th</sup> mtg., para. 15, U.N. Doc. CCPR/C/79/Add.104 (1999); *Concluding Observations of the Human Rights Committee: Guatemala*, 72<sup>nd</sup> Sess., 1040-1042<sup>nd</sup> mtg., para. 19, U.N. Doc. CCPR/CO/72/GTM (2001); *Concluding Observations of the Human Rights Committee: Honduras*, 88<sup>th</sup> Sess., 2398-2400<sup>th</sup> mtg., para. 8, U.N. Doc. CCPR/C/HND/CO/1 (2006); *Concluding Observations of the Human Rights Committee: Mauritius*, 83<sup>rd</sup> Sess., 2261-2262<sup>nd</sup> mtg., para. 9, U.N. Doc. CCPR/CO/83/MUS (2005); *Concluding Observations of the Human Rights Committee:*

- Morocco, 82<sup>nd</sup> Sess., 2234-2236<sup>th</sup> mtg., para. 29, U.N. Doc. CCPR/CO/82/MAR (2004); *Concluding Observations of the Human Rights Committee: Paraguay*, 85<sup>th</sup> Sess., 2315-2317<sup>th</sup> mtg., para. 10, U.N. Doc. CCPR/C/PRY/CO/2 (2006); *Concluding Observations of the Human Rights Committee: Peru*, 70<sup>th</sup> Sess., 1879 – 1892<sup>nd</sup> mtg., para. 20, U.N. Doc. CCPR/CO/70/PER (2000); *Concluding Observations of the Human Rights Committee: Poland*, 82<sup>nd</sup> Sess., 2240-2241<sup>st</sup> mtg., para. 8, U.N. Doc. CCPR/CO/82/POL (2004); *Concluding Observations of the Human Rights Committee: Senegal*, 61<sup>st</sup> Sess., 1618-1619<sup>th</sup> mtg., para. 12, U.N. Doc. CCPR/C/79/Add 82 (1997); *Concluding Observations of the Human Rights Committee: Sri Lanka*, 79<sup>th</sup> Sess., 2156-2157<sup>th</sup> mtg., para. 12, CCPR/CO/79/LKA (2003); *Concluding Observations of the Human Rights Committee: Venezuela*, 71<sup>st</sup> Sess., 1899-1900<sup>th</sup> mtg., para. 19, U.N. Doc. CCPR/CO/71/VEN (2001); *Concluding Observations of the Human Rights Committee: El Salvador*, 78<sup>th</sup> Sess., 2113-2115 mtg., para. 14, U.N. Doc. CCPR/CO/78/SLV (2003); *Concluding Observations of the Human Rights Committee: Guatemala*, 72<sup>nd</sup> Sess., 1940-1942<sup>nd</sup> mtg., para. 19, U.N. Doc. CCPR/CO/72/GTM (2001); *Concluding Observations of the Human Rights Committee: Kenya*, 83<sup>rd</sup> Sess., 2255-2256<sup>th</sup> mtg., para. 14, U.N. Doc. CCPR/CO/83/KEN (2005); *Concluding Observations of the Human Rights Committee: Mauritius*, 83<sup>rd</sup> Sess., 2261-2262<sup>nd</sup> mtg., para. 9, U.N. Doc. CCPR/CO/83/MUS (2005); *Concluding Observations of the Human Rights Committee: Peru*, 70<sup>th</sup> Sess., 1879-1881<sup>st</sup> mtg., para. 20, U.N. Doc. CCPR/CO/70/PER (2000); *Concluding Observations of the Human Rights Committee: United Republic of Tanzania*, 63<sup>rd</sup> Sess., 1689-1690<sup>th</sup> mtg., para. 15, U.N. Doc. CCPR/C/79/Add.97 (1998); *Concluding Observations of the Human Rights Committee: Venezuela*, 71<sup>st</sup> Sess., 1899-1900<sup>th</sup> mtg., para. 19, U.N. Doc. CCPR/CO/71/VEN (2001).
- 206 See, e.g., *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Bolivia*, 40<sup>th</sup> Sess., 811-812<sup>th</sup> mtg., paras. 42-43, U.N. Doc. CEDAW/C/BOL/CO/4 (2008); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Colombia*, 37<sup>th</sup> Sess., 769-770<sup>th</sup> mtg., paras. 22-23, U.N. Doc. CEDAW/C/COL/CO/6 (2007); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Jamaica*, 36<sup>th</sup> Sess., 745-746<sup>th</sup> mtg., paras. 35-36, U.N. Doc. CEDAW/C/JAM/CO/5 (2006); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Mexico*, 36<sup>th</sup> Sess., 751-752<sup>nd</sup> mtg., paras. 32-33, U.N. Doc. CEDAW/C/MEX/CO/6 (2006); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Peru*, 37<sup>th</sup> Sess., 763-764<sup>th</sup> mtg., paras. 24-25, U.N. Doc. CEDAW/C/PER/CO/6 (2007); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Republic of Moldova*, 36<sup>th</sup> Sess., 749-750<sup>th</sup> mtg., paras. 30-31, U.N. Doc. CEDAW/C/MDA/CO/3 (2006); *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Saint Lucia*, 35<sup>th</sup> Sess., 729-730<sup>th</sup> mtg., paras. 31-32, U.N. Doc. CEDAW/C/LCA/CO/6 (2006).
- 207 See *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Burkina Faso*, 22-23<sup>rd</sup> Sess., 458 – 459<sup>th</sup> mtg., para. 276, U.N. Doc. A/55/38 (2000).
- 208 See *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Dominican Republic*, *supra* note 205, at para. 309, U.N. Doc. A/59/38 (SUPP) (2004).
- 209 *ICPD Programme of Action*, *supra* note 197, at para. 7.3; see ICESCR, *supra* note 197, at art. 12(1) (recognizing the right of everyone to “the highest attainable standard of physical and mental health”).
- 210 Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health*, para. 21, (22<sup>nd</sup> Sess., 2000) U.N. Doc. E/C.12/2000/4 (2000) [hereinafter CESCR, *General Comment 14*].
- 211 *Id.*, at para. 12(b).
- 212 *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report on Maternal Mortality and Access to Medicines*, 61<sup>st</sup> Sess., para. 17(c), 21, U.N. Doc. A/61/338 (2006), para. 17(c); CESCR, *General Comment 14*, *supra* note 210, at para. 12(b).
- 213 *Beijing Declaration and Platform for Action*, *supra* note 197, at para. 97.
- 214 CERD, *supra* note 197, at art. 5(e) (iv); CESCR *General Comment 14*, *supra* note 210, at para. 12(b).
- 215 See *Concluding Observations of the Committee on the Elimination of Racial Discrimination: China*, 58-59<sup>th</sup> Sess., 1438-1493<sup>rd</sup> mtg., para. 250, U.N. Doc. A/56/18 (2001) (recommending that the next State party report contain “information on measures taken to prevent gender-related racial discrimination, including in the area of... reproductive health.”) [hereinafter CERD, *Concluding Observations: China*]; *Concluding Observations of the Committee on the Elimination of Racial Discrimination: India*, 70<sup>th</sup> Sess., 1796-1797 mtg., para. 24, U.N. Doc. CERD/C/IND/

- CO/19 (2007) (recommending “that the State party ensure equal access to...reproductive health services...”) [hereinafter CERD, *Concluding Observations: India*]. See also United Nations Economic and Social Council, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt*, 59<sup>th</sup> Sess., para. 25, UN Doc. E/CN.4/2003/58(2003) (“[t]he right to health is a broad concept that can be broken down into more specific entitlements such as the rights to...[m]aternal, child and reproductive health.”).
- 216 See, e.g., CERD, *Concluding Observations: China*, *supra* note 215, at para. 250; CERD, *Concluding Observations: India*, *supra* note 215, at para. 24; *Concluding Observations of the Committee on the Elimination of Racial Discrimination: Uganda*, 62<sup>nd</sup> Sess., 1562-1563<sup>rd</sup> mtg., para. 18, U.N. Doc. CERD/C/62/CO/11 (2003).
- 217 *Concluding Observations of the Committee on the Elimination of Racial Discrimination: United States of America*, 58-59<sup>th</sup> Sess., 138-149<sup>th</sup> mtg., para. 403, U.N. Doc. A/56/18 (2001) (recommending that “the next State party report contain socio-economic data, disaggregated by race, ethnic origin and gender...”).
- 218 MEGAN THOMAS & CARA JAMES, KAISER FAMILY FOUNDATION, ISSUE BRIEF: THE ROLE OF HEALTH COVERAGE FOR COMMUNITIES OF COLOR 2 (Nov. 2009), <http://www.kff.org/healthreform/upload/8017.pdf>.
- 219 Nat’l Network of Abortion Funds, *supra* note 42.
- 220 See Universal Declaration of Human Rights, *adopted* Dec. 10, 1948, G.A. Res. 217A (III), art. 3, U.N. Doc. A/810 (1948); ICCPR, *supra* note 197, at arts. 6.1, 9.1; Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, U.N. GAOR, 44<sup>th</sup> Sess., Supp. No. 49, arts 6.1, 6.2 U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990) [hereinafter CRC]; ICPD *Programme of Action*, *supra* note 197, at paras. 7.3, 7.15, 8.34; *Beijing Declaration and the Platform for Action*, at paras. 96, 106, 108.
- 221 See ICCPR, *supra* note 197, at art. 17.1; CRC, *supra* note 221, at arts. 16.1, 16.2; ICPD *Programme of Action*, *supra* note 197, at para. 7.45; *Beijing Declaration and the Platform for Action*, *supra* note 197, at paras. 106, 107.
- 222 See CEDAW, *supra* note 197, at art. 16 (1.e); ICPD *Programme of Action*, *supra* note 197, at principle 8; *Beijing Declaration and the Platform for Action*, *supra* note 197, at para. 223.
- 223 *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Nepal*, 26<sup>th</sup> Sess., 44-46<sup>th</sup>, 55<sup>th</sup> mtg., para. 32, note 12, U.N. Doc. E/C.12/1/Add.66 (2001).
- 224 Committee on the Elimination of Discrimination against Women, *General Comment 24*, para. 14, (20<sup>th</sup> Sess., 1999) U.N. Doc. A/54/38/Rev.1 (1999).
- 225 Rachel K. Jones et al., *supra* note 13, at 24.
- 226 Kaiser Fam. Found., *supra* note 46.
- 227 18- 37 percent of women end up carrying to term, according to studies. See Ctr. for Disease Control, *supra* note 5; Trussell et al., *supra* note 5; Torres et al., *supra* note 5; Blanket et al., *supra* note 5; Cook et al., *supra* note 5; Morgan & Parnell, *supra* note 5; Henshaw et al. *supra* note 5.
- 228 Nat’l Network of Abortion Funds, *supra* note 42, at 19.
- 229 *Id.*
- 230 The seventeen states that use state funds to cover abortions are: Alaska, Arizona, California, Connecticut, Hawaii, Idaho, Illinois, Maryland, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, New York, Oregon, Vermont, Washington, and West Virginia. These states are referred to as “non-discrimination states” in the report. Of these states, only four – West Virginia, New York, Hawaii, and Maryland – provide such coverage voluntarily; the others do so pursuant to court orders. GUTTMACHER INST., *supra* note 64. In addition, as of August 1, 2010, the District of Columbia funds all medically necessary abortions.
- 231 Twenty-six states prohibit the use of their state Medicaid funds for abortion except in cases of rape, incest, or life endangerment, in line with the restrictions imposed by the Hyde Amendment. These states are referred to as “Hyde states” in the report. South Dakota only funds abortions in cases of life endangerment, in violation of Hyde. *Id.*
- 232 Iowa and Mississippi provide state Medicaid coverage in cases of rape, incest, and life endangerment, as required by Hyde, as well as in cases of fetal abnormality. Indiana, South Carolina, Utah and Wisconsin go beyond the requirements of Hyde to provide Medicaid coverage for abortion in cases where continuing the pregnancy would endanger the physical health of the pregnant woman. *Id.* These six states are referred to as “Hyde plus states” in the report.
- 233 See, e.g., Nat’l Network of Abortion Funds, *The Hyde Amendment: A Violation of Human Rights*, <http://www.nnaf.org/pdf/Hyde%20and%20Human%20Rights%20-%20web.pdf> (last visited Jul. 27, 2010).
- 234 See Nat’l Network of Abortion Funds, *supra* note 42. See also Ctr. for Disease Control, *supra* note 5; Trussell et al., *supra* note 5; Torres et al., *supra* note 5; Blank et al., *supra* note 5; Cook et al., *supra* note 5; Morgan &

[www.reproductiverights.org](http://www.reproductiverights.org)

**Center for Reproductive Rights**

120 Wall Street, 14th Floor  
New York, NY 10005  
United States

Tel +1 917 637 3600  
Fax +1 917 637 3666

[info@reprorights.org](mailto:info@reprorights.org)

CENTER  
FOR  
REPRODUCTIVE  
RIGHTS