Hyde and Seek: Searching for Solutions to The Hyde Amendment's Financial Barriers to Abortion

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Keywords: abortion; reproductive rights; Hyde Amendment; EACH Act; medical policy; family planning.

Executive Summary: The Hyde Amendment (Hyde) hinders abortion access to people who can become pregnant (we will refer to this cohort henceforth as "women" and recognize that not all people who can become pregnant identify as such) whose health insurance is funded by the federal government. In the forty-five years since its inception, the Hyde Amendment has disproportionately affected marginalized women. The conservative movement has augmented disparities in healthcare by passing incremental laws to restrict abortion access, including but not limited to, gestational age and specific procedure limitations, waiting periods, parental consent, and Targeted Regulation of Abortion Providers (TRAP) laws. With Roe V. Wade overturned with the Dobbs V. Jackson ruling (Dobbs), access to abortion is more restricted than it has been in the past 50 years. Eight states have completely banned abortion and many other states offer very limited exceptions to the ban. Now, more than ever, it is essential that funding is not a barrier to care in the states that continue to protect abortion rights. Our first recommendation calls for states to be held accountable to the minimal federal requirements set forth by Hyde and create a confidential forum for women to report informal barriers to care. Furthermore, we endorse the passing of the Equal Access to Abortion Coverage in Health Insurance Act (EACH Act), which would permanently end the renewal of Hyde. Our final recommendation calls on the government to create legislation that permanently institutes national mandatory guidelines for emergency obstetric care. These steps could counteract the increasingly restrictive encroachment on abortion rights.

I. A Charge Against Reproductive Rights: The Hyde Amendment

The Hyde Amendment withholds federal funds from covering abortion services in nearly all circumstances except rape, incest, or life endangerment (Guttmatcher Institute 2021). Initiated in 1977 as a temporary rider, or provision added to bills, Hyde initially only made exceptions for life endangerment. Over the years, Hyde has remained a contentious subject and alterations to the exceptions of the funding ban have varied constantly (ACLU 2022). Hyde continued to be renewed annually as a rider to federal funding bills until 2021, which marks the first time the House of Representatives passed a funding package without it (Salganicoff 2021). Impoverished women on federal assistance programs such as Medicaid and Children's Health Insurance Program are often highlighted in abortion debates. However, it is often understated that Hyde impacts people of many backgrounds. Many groups on federally funded insurances are impacted, including federal employees, veterans, active-duty military and their spouses, Washington D.C. residents, Native Americans on the Indian Health Service, federal prisoners, Medicare beneficiaries, and Peace Corps volunteers.

Hyde is only marginally effective in achieving its intended goal of deterring Americans from seeking abortions. Abortion rates today are the lowest since 1973, which can be attributed primarily to improved contraception and the subsequent decline in unintended pregnancy rates (Finer 2016). Exploration of the short and long-term impacts of the Hyde amendment might provide new insight. Although the bill was intended to save government funds, upon further analysis, Hyde financially hinders the country and its citizens.

II. Hyde Amendment's Socio-Economic Impact on the Individual Woman & the Country

Abortions are financially burdensome. The average price of an early abortion at 10 weeks gestation is $500 and doubles at 20 weeks of gestation, to a median price of $1,195.90 (Jones et al. 2018). Women marginalized by Hyde are prone to present later in pregnancy for abortion care because they must rely on financial assistance to pay for the procedure and often live more than 25 miles from a provider (Jones et al. 2017). For example, Peace Corps volunteers must travel back to the U.S. to pay out of pocket for abortion care, all while receiving a meager $250–300/month stipend (Foster et al. 2015). Similarly, military healthcare does not provide family planning resources or funding. Those on active duty must request time off and risk confidentiality. They must find a provider off the military base, potentially requiring travel abroad to access the procedure. Professional repercussions such as health discrimination could ensue for those developing medical complications and consequential prolonged time off after abortions. (Grindlay et al. 2011).

Hyde disproportionately impacts low-income women of color and further enhances disparities in health care. For women that do receive abortions, approximately 75% of them are low-income; (Guttmatcher Institute 2021) many are already living at or below the federal poverty line (FPL), which is $13,950 in a single person household (Salganicoff 2021). Women of color are disproportionately more likely to have low incomes and to be insured through Medicaid. Compared to 15% of white women insured through Medicaid, 33% of Black women, 30% of Hispanic, and 34% of Indigenous women were on Medicaid in 2019 (Salganicoff 2021). For these impoverished women, nearly one third of their monthly income must be diverted from paying for rent or food to cover abortion costs (Roberts et al. 2014). Women who want to but cannot access abortion are at four times greater odds of living below the FPL and remaining below the FPL for up to 4 years after birth compared to those who accessed a desired abortion (Miller et al. 2020; Miller et al. 2022). With the current funding limitations imposed by Hyde, marginalized women must sacrifice their upward mobility and choose between caring for a child or paying for an abortion, both of which they cannot afford.

The restrictions imposed by Hyde cause a ripple effect on the country as a whole. In a hypothetical situation with zero state-level abortion restrictions, 505,000 more women would be in the labor force (Hayes et al. 2021). An estimated $105 billion is lost each year per state as a result of reductions in labor force with current abortion restrictions (Baker 2021). Numerous studies found that abortion legalization influenced the economy secondary to increased education, labor prestige, and individual earnings (Myers and Welch 2021). The national GDP would rise by an estimated 0.5% if all restrictions were lifted (Hayes et al. 2021). Collectively, the financial burden of abortions to the country is far less than childbirth. Compared to the cost of an abortion, the Medicaid price for maternal and newborn care for a vaginal and cesarean section birth averages $29,800 and $50,373, respectively (Truven Health Analytics 2013). The cost to social support programs to care for both mother and child is also significant, as children comprise the largest percentage of welfare beneficiaries at 41% (Minton et al. 2019). Although these socioeconomic changes impact all Americans, they inordinately impact women marginalized by Hyde and those living in poverty.

III. State Resistance of Mandated Reproductive Rights Funding

Prior to the overturn of Roe V. Wade, not all states were compliant with Hyde's minimum federal requirements and some states interpreted how to execute federal laws. South Dakota (S.D.) was a key example, as this state provided Medicaid coverage for abortions only in cases of life endangerment, but not for cases of rape or incest (GAO-19-159). S.D.

violated federal law without any legal repercussions from federal oversight, including the Centers for Medicare & Medicaid Service (CMS). With the ruling of Dobbs, S.D. now completely bans abortions with no exceptions for rape or incest, and thus Hyde Amendment no longer applies to this state (Guttmacher 2022). However, this is not the only example of non-compliance. Pre-Dobbs, only 16 states chose to allot their own funds for medical and surgical abortions outside of the situations detailed by Hyde (**Figure 1**). While 37 states report they specifically cover medication-induced abortions, only 13 of these states actually requested a reimbursement for the medication. This may be due to a state's preference of abortion procedure, or may suggest the presence of informal, undocumented barriers to access. Countless women will continue to experience obscure obstacles to care unless policy is changed to make access to reproductive rights more equitable.

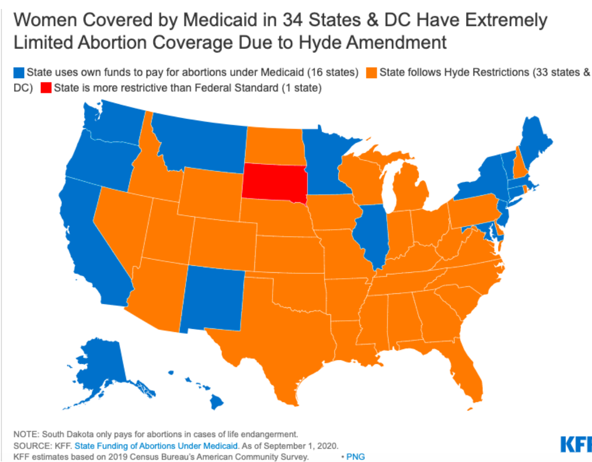

Figure 1: Map of the United States depicting state limits to abortion coverage due to Hyde and how it impacts women covered by Medicaid. Post Roe V. Wade, there are eight states (South Dakota, Wisconsin, Montana, Oklahoma, Arkansas, Mississippi, Alabama, and Texas) that completely ban abortion and thus no longer apply to the Hyde Amendment. Source: https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services/

IV. The Current State of Affairs in the Wake of Dobbs V. Jackson: The Privatization of Abortions

Women impacted by Hyde now face more legal and financial barriers to care than ever, as Dobbs effectively ensures that states control both financial and legal support for abortion access. Dobbs has effectively privatized abortions. In response to the new ruling, numerous corporations are pledging financial assistance for the cost of an abortion and interstate travel. While this approach benefits a small subset of women, it will further enhance the health inequities that exist in America. The unemployed and federally insured citizens will continue to face monetary and legal barriers to accessing an abortion.

Additional barriers to care include the legality of interstate abortion care. The legal precedent of out-of-state abortion jurisprudence is complex. It is a historically uncommon route of legislation, and the precedent is not as concrete as the Dobbs ruling, which explicitly gives the states the power to determine intrastate abortion regulations. Some conservative states are proposing to illegalize attaining interstate health care.

Furthermore, health insurance coverage is rapidly evolving in light of the novel interstate debates. Most health insurance in America is structured to pay for medical care in the state an individual lives and works in; however, interstate medical care is usually covered in the case of emergencies. President Biden's July Executive Order addresses both interstate abortion regulations and emergent abortion care. It seeks to protect emergency medical care for pregnant women and women experiencing pregnancy loss. It also clarifies and protects physician autonomy in the context of the Emergency Medical Treatment and Labor Act (EMTALA) (The White House 2022).

VI. Policy Options

i. Recommendation 1: Ensure states abide by the minimum federal regulations and create a confidential forum for women to report informal barriers to care

We propose that the Centers for Medicare & Medicaid Service (CMS) take legal action to ensure that states comply with covering the reimbursement of mifepristone. Therefore, it is imperative that in states where abortion is not banned, women can have the cost of this medication covered by their insurance as mandated by Hyde. We call on the Global Abortion Policies Database (GAPD), a comprehensive database that details and compares

global abortion policies and guidelines, to expand an American branch of their network to help identify barriers to accessing medication-abortion. Women need a confidential forum in which they can self-report informal barriers to care that they experience. Patient identity should remain confidential and compliant with HIPAA guidelines. We propose healthcare and legal professionals can be recruited to pro-bono volunteer to assist with a U.S. branch of the GAPD. This action arm of the GAPD will access the forum's information to advocate on behalf of these women. They can identify delays in care through the proper channels and expedite the process of obtaining mifepristone.

Advantages:

- No novel legislation is required to be passed, simply ensure accountability for state governments through a self-reporting database.
- Understand the barriers to receiving funding for a medication-induced abortion in the case of life endangerment, rape, or incest. For example, while some states report compliance with Hyde, a database would shed light on the causes of discrepancy in prescriptions for medication-induced abortions. Understanding specific barriers to care will allow the action arm of GAPD to take purposeful action toward resolving the discrepancies.
- The collective data from the forum could assist abortion rights organizations to forecast specific barriers to care and proactively streamline the process for all women.
- Ensures that states comply with the minimum federal law set forth by Hyde, so that future steps towards expanding coverage for abortion can be accepted and implemented.

Disadvantages:

- The process for receiving Medicaid coverage for an abortion entails invasive requirements. Some states require a provider to certify a patient's life is endangered, or a patient must legally document that rape or incest occurred. The intensity of these requirements is decided by each state and will continue to serve as a major barrier to obtain abortion coverage. Therefore, enforcing Hyde will still not allow many women to access abortion.
- Abortions for cases of life endangerment, rape, and incest are severely limited scenarios and do not encompass the variety of reasons a woman may seek an abortion.

ii. Recommendation 2: endorse the EACH Act (S.1021/H.R.2234 introduced March 2021) and permanently repeal Hyde to reduce financial barriers to care

We propose that Congress permanently end the Hyde Amendment by supporting the passage of the EACH Act to expand coverage to anyone with federally funded insurance. The EACH Act explicitly prohibits federal and state governments from restricting insurance coverage for abortion in both public and private health insurance programs.

Furthermore, legislators must take care to ensure language in these and future bills are founded in medically accurate terminology. For example, legal documents describe "partial birth abortions", a non-medical term coined to incite imagery and evoke emotion. It is often used in politics to allude to the dilation and extraction procedure, a procedure rarely used but often at the forefront of the abortion debates. It is imperative to keep the focus on the evidence-based medical care of women. The Offices of Legislature Service and Congressional Research Service (CRS) should be mandated to collaborate with committees composed of healthcare providers to ensure legal documents incorporate medical expertise. CRS reports should disclose extensive details of their authors' credentials and experience in the field of discussion.

Advantages:

- If Hyde were permanently repealed, the 7.7 million women of reproductive age in 33 states and Washington, D.C. would receive government financial support for abortions. Furthermore, the EACH act would expand coverage without discrimination based on a woman's reason for abortion. Both elective

and medically necessary abortions could be covered by Medicaid.
- Expanding abortion coverage will decrease existing disparities in abortion access for marginalized women and enable them to exercise their reproductive rights without financial barriers.
- Use of scientifically accurate terminology in reproductive bills is essential for bipartisan progress. Neutral, universal terminology may foster a more transparent, effective, and professional environment surrounding issues which are often driven by emotionally charged rhetoric.

Disadvantages:

- After the Dobbs decision, there are eight states where abortion is already banned, and it is expected that other states will begin to severely restrict abortion access as well. Women in these states will not benefit from the EACH Act's financial accommodations. Given the rapidly-evolving nature of legal changes happening in the post-Roe world, it is unclear what the precedent will be surrounding the ability of women to use federal funds for reproductive health care.
- The extent of changes by state would vary based on availability of providers, unique state laws, and reimbursement rates. Women in more permissive states would benefit the most from federally funded abortions, while little change would happen in more restrictive states.
- Overturning Hyde nationally would not impact states that outlaw abortion.

iii. Recommendation 3: introduce legislation to permanently standardize national access to emergency obstetric care

While President Biden's executive order is an excellent response to the rapidly evolving abortion landscape, executive orders are not permanent and can be revoked by future Presidents. Swift action must be taken to permanently safeguard emergency obstetric care that can withstand changes to the political climate. We call on the legislative branch to propose a bill that creates national guidelines on emergency obstetric care as an integral part of EMTALA.

Advantages:

- Certain states aim to prevent their citizens from accessing care in other states. By nationalizing the standard of emergency obstetric care, this recommendation would supersede state laws and protect women crossing state lines in emergent situations.
- Reproductive health physicians would be protected from legal action when providing life saving obstetric interventions. Without protection, physicians may be forced to provide inadequate treatments to women because of the legal restraints in their state.

Disadvantages:

- Emergent, life threatening conditions do not encompass all the reasons women may seek an abortion.
- The ongoing legal climate surrounding these issues is volatile and healthcare is now subject to the ebb and flow of state and national restrictions.

VII. Policy Recommendation

This policy memorandum arranges options from the minimum level of change that needs to occur to the most ambitious. Abortion rights is a multifaceted issue, and our recommendations aim to ameliorate some barriers to care. Recommendation one ensures that all states comply with the basic abortion coverage for cases of rape, incest, and life endangerment. This policy recommendation is important; however, significant change is needed to encompass all women. Recommendation two expands this coverage to scenarios beyond the severely restrictive cases to ensure there is adequate coverage for all women currently impacted by Hyde. Current political and financial efforts to combat the impacts of Dobbs will disproportionately protect privately insured citizens more than those impacted by Hyde. Therefore, recommendation three discusses a route to permanently protect emergency obstetric care for all women. The fate for women impacted by Hyde will continue to be tenuous as state and federal authorities define the boundaries and implications of the Dobbs V. Jackson ruling. As

such, it will be essential to follow decisions at every level each step of the way.

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Acknowledgements

The Authors would like to thank Science Policy and Advocacy at Rutgers (SPAR) and Rutgers-New Jersey Medical School for supporting this work.

Disclaimer

The views expressed in this paper are the Authors' opinions and are independent of Rutgers- New Jersey Medical School.