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 [32]

Under the federal Medicaid program,[33] federal and state governments jointly pay for healthcare services for eligible poor and low-income individuals and their families.[34] Medicaid is the largest source of funding for medical and health-related services for low-income and indigent people in the United States.[35] It currently provides health and long-term care services to 60 million individuals, including children and parents, persons with disabilities, and seniors.[36] 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.[37] Thirty-seven percent of women of reproductive age in families with incomes below the federal poverty level rely on Medicaid for healthcare coverage.[38] 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."[39]

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.[40] 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.[41]

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[46]—$24,352 to $33,874 for a family of three in 2009/2010.[47] 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.[48] 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."[49] 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.[50] 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.[51] 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.[52] Recognizing that the Hyde Amendment undermines poor women's constitutional right to abortion, four justices dissented from the decision. "[T]he Hyde Amendment," 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." [53] 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."[54] **(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.[64] 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.[42] **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).[43] It also permitted states to permanently deny Medicaid benefits to non-citizens.[44]

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.[45] 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,[55] an additional five European nations and Israel[56] 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.[57] 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."[58] 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,[59] 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.[60] 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.[61] 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.[62] **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.[63]

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.[65] 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[66] and that selectively denying benefits to women exercising a fundamental right violates equal protection.[67] **(See Table: State Funding for Abortion under Medicaid.)**