



## **¡SIN SEGURO, NO MÁS! WITHOUT COVERAGE, NO MORE: LATINXS<sup>1</sup> ACCESS TO ABORTION UNDER HYDE**

**“I certainly would 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.”**

*— U.S. Representative Henry Hyde (R-IL), 1977 Medicaid debate*

### **THE HYDE AMENDMENT: HOW WE GOT FROM ROE V. WADE TO ROSIE JIMENEZ**

While *Roe* enshrined the right to safe, legal abortion in concept, it did nothing to ensure that those services would be available or affordable. The Hyde Amendment, passed yearly by Congress in federal appropriations legislation, bans federal funding for abortion except in cases of rape, incest, and life endangerment.<sup>2</sup> As first introduced by Representative Henry Hyde III (R-IL) in 1976, it banned only federal Medicaid coverage of abortion. After the Hyde Amendment was introduced, and subsequently passed each year since, similar policies have proliferated throughout appropriations legislation, with similar amendments finding their way into nearly every spending bill. Currently, restrictions on abortion coverage deny affordable abortion services to a growing segment of the population, including: Medicaid-eligible individuals and Medicare and CHIP beneficiaries; Federal employees and their dependents; Peace Corps volunteers; Native American communities; individuals in federal prisons and detention centers, including those detained for immigration purposes; military personnel and veterans, use by the District of Columbia of its own funds for abortion coverage for low-income people.<sup>3</sup>

The intent of the policy's author is of no question, as Rep. Hyde himself told his colleagues during a congressional debate over Medicaid funding in 1977: “I certainly would 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 available vehicle is the... Medicaid bill.” For low-income people, the result of the Hyde Amendment has been their ability to access safe and affordable abortion care is once again left up to the states, as state legislatures can decide whether they provide state funds in order to ensure that Medicaid in their states includes abortion coverage.

Currently 17 states have decided (or are required by court order) to cover abortion care with state Medicaid funds.<sup>4</sup> As a result, the disparities between states that do and do not provide abortion coverage are exacerbated and leaves people's reproductive health in the hands of the state legislatures or judges. Furthermore, these 17 states have largely resisted or rejected restrictions on abortion providers and those seeking abortion care. Thirty-three states and

the District of Columbia follow the federal standard and only cover abortions in their Medicaid programs in cases of life endangerment, rape, or incest.<sup>5</sup> Of the 7.5 million women of reproductive age with Medicaid coverage in these states that do not cover abortion, just over half were women of color (51 percent in 2015).<sup>6</sup> Therefore, taken together, new state-level restrictions and longstanding bans on insurance coverage for abortion divide the country in two: the states with fewer restrictions and where state funds are used to cover abortion, and states where politicians both severely restrict and deny insurance coverage for abortion services. Data from the U.S. Census indicates that today, nearly half of Latinas and approximately 70 percent of Black women, and a majority of all women of color, live in the latter, doubly hostile states.<sup>7</sup>

### **Rosie Jiménez**



Shortly after the Hyde Amendment was first enacted, it claimed the life of a Latina who earned a low income. Rosie Jiménez was a 27-year-old college student and single mother who became pregnant after *Roe v. Wade* made abortion legal. She qualified

for Medicaid, but because the Hyde Amendment had gone into effect two months earlier, she couldn't get coverage for an abortion. Rosie was six months away from graduating with a teaching credential, a ticket to a better life for her and her five-year-old daughter. Unable to raise the money to pay for a legal abortion, she turned to an unsafe and illegal procedure. On October 3, 1977, Rosie died of septic shock, the first known victim of the Hyde Amendment, and a painful reminder that legal abortion means little to a community that has no ability to access it.



## ECONOMIC INJUSTICE: Hyde forces those who earn low incomes in the Latinx community to pay for abortion care out-of-pocket



Nearly one in three Latinas of reproductive age  
are enrolled in the Medicaid program\*



of Latinas live  
in poverty\*\*

\*<https://www.gutmacher.org/evidence-you-can-use/medicaid-funding-abortion>

\*\*<https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/09/Poverty-Snapshot-Factsheet-2017.pdf>

### THE IMPACT OF HYDE IN REAL PEOPLE'S LIVES

Women of color are more likely to receive their healthcare from a program, insurer, or employer affected by these bans, only exacerbating the existing healthcare disparities and the ongoing impact of these bans on Latinas and other women of color.<sup>8</sup> Abortion access is an essential component of reproductive healthcare that 18 percent of Latinas will need over their lifetime, compared to only 10 percent of their white counterparts.<sup>9</sup> While abortion remains a safe, legal, and constitutionally-protected form of medical care in the United States, the federal restrictions on insurance coverage, exacerbated by increasing federal and state attacks attempting to limit access to abortion care, combine to render the constitutional right meaningless in the face of often insurmountable obstacles. Thus, millions of people in underserved communities currently lack access to abortion care, and are already living in a *post-Roe* world due to systemic barriers such as cost, lack of available clinics, insufficient culturally and linguistically competent health systems, and discriminatory immigration policies.

Due to systemic barriers and discrimination, a disproportionately higher number of women of color are enrolled in the Medicaid program and thereby denied abortion coverage under the Hyde Amendment.<sup>10</sup> Nearly one-third (31 percent) of Black women of reproductive age and 27 percent of Latinas of reproductive age are enrolled in the Medicaid program.<sup>11</sup> In the aggregate, nearly one-

fifth (19 percent) of Asian Americans and Pacific Islander women are enrolled in the program, while enrollment rates for certain Asian ethnic subgroups are much higher (at 62 percent of Bhutanese women, 43 percent of Hmong women and 32 percent of Pakistani women).<sup>12</sup> Medicaid also provides coverage to more than one in four (27 percent) nonelderly American Indian and Alaska Native (AIAN) adults and half of AIAN children.<sup>13</sup> Latinas, and other people of color, are also more likely to live in poverty and thus less likely to be able to afford abortion care (or other healthcare) out-of-pocket.<sup>14</sup> The time that it takes to raise funds for the care they need, often results in delays from when a person has made a decision to when they are able to afford it, which in turn increases the cost of abortion care. In a 2014 study, the average costs to patients for first-trimester abortion care was \$461, and anywhere from \$860 to \$1874 for second-trimester abortion care.<sup>15</sup>

Bans on insurance coverage for abortion put Latinxs and their families in untenable economic situations. For many who qualify and enroll in Medicaid, the cost of ending a pregnancy forces them to choose between paying for rent or groceries and paying for the care they need. Research shows that one in four low-income women on Medicaid who seek abortion care is unable to afford to pay out-of-pocket cost and is forced to carry the pregnancy to term.<sup>16</sup> A woman who wants to get an abortion but is denied is more likely to fall into poverty than one who can get an abortion.<sup>17</sup>

### STATE BATTLEGROUND: HOW RESTRICTIONS IN THE STATES COMPROMISE LATINX HEALTH AND DECISION-MAKING

The harms of the Hyde Amendment are exacerbated and confounded by state-level restrictions on abortion. Since 2011, politicians have passed 401 new laws in 33 states across the country that shame, pressure, and punish people who have decided to have an abortion.<sup>18</sup> Already, 57 percent of U.S. women of reproductive age live in states classified as hostile or very hostile to abortion rights.<sup>19</sup>

These new laws have forced doctors to give patients medically-false information about abortion, including that abortion leads to

breast cancer, required young people to secure parental consent for abortion, and in some states required people to make multiple, medically-unnecessary appointments for care. Others would ban abortion at a particular point in pregnancy, as early as six weeks, before a person might even know they are pregnant. Other laws have required clinics to meet medically unnecessary licensing requirements that force clinics to close down, such as the law in Texas that was struck down by the Supreme Court that would have shuttered 75% of its clinics.<sup>20</sup>



The gap is widening between those states where a person can find an abortion provider and access care in a safe and affordable manner, and those states where abortion services are almost altogether out of reach. These restrictions disproportionately affect low-income people of color who are forced to travel long distances and pay steep fees out-of-pocket to obtain abortion care. As restrictions increase, and clinics close down, the landscape is looking increasingly like the *pre-Roe* landscape. People who can afford to do so travel long distances and across

state lines to obtain abortion care. Those who cannot afford to pay out-of-pocket have much more limited access. Undocumented Latinx immigrants, many of whom cannot travel for fear of detention and deportation, have even fewer options. For many Latinxs, especially for those who are living with low-incomes, are uninsured, or underinsured, *Roe v. Wade* is an abstract promise with little bearing on their reality. In some cases, these endless hurdles act as a complete obstacle and will force some people to carry an unwanted pregnancy to term.

## POLICY RECOMMENDATIONS

### ⊕ Lift all federal bans on insurance coverage for abortion.

- Remove all language in annual appropriations legislation that restricts coverage for or provision of abortion care in public health insurance programs. This includes repeal of the Hyde Amendment, and all policies that restrict funding for abortion care and coverage for: Medicaid-eligible individuals and Medicare and CHIP beneficiaries; Federal employees and their dependents; Peace Corp volunteers; Native American communities; people in federal prisons and detention centers, including those detained for immigration purposes; and use by the District of Columbia of its own funds for abortion coverage for low-income people. Eliminate federal restrictions on abortion coverage in private insurance plans.
- Enact the Equal Access to Abortion Coverage in Health Insurance Act (EACH Woman Act) and other proactive legislation to permanently repeal abortion coverage bans and prohibit states from interfering with abortion coverage in private insurance plans, including in state healthcare exchanges.

### ⊕ Additional Recommendations

- Repeal and oppose legislation that restricts access to abortion services, including but not limited to: bans on race or sex-selective abortion; pre-viability abortion plans; “personhood” amendments; and restrictions on abortion access for young people.

- Enact the Women’s Health Protection Act (WHPA) and other legislation that expands access to abortion care, including the pool of licensed, qualified providers.
- Reduce unintended pregnancy by increasing funding to the Title X family planning program.
- Support the Health Equity and Access under the Law (HEAL) for Immigrant Women and Families Act which, among other provisions, would restore eligibility for Medicaid and CHIP to immigrants who are lawfully present without making them endure the current five-year waiting period.
- Support the Health Equity and Accountability Act (HEAA), comprehensive legislation designed to eliminate racial and ethnic disparities. Introduced each Congress by the Tri-Caucus, this is the only legislation that holistically addresses health inequities with an intersectional lens that includes immigration status, age, disability, sex, gender, sexual orientation, gender identity and expression, language, and socio-economic status.
- Strongly oppose all legislative and administrative proposals that weaken Medicaid, such as proposals that implement work requirements or loosen the standards for section 1115 demonstrations.
- Support measures that improve economic security for Latinxs by increasing the minimum wage, closing the race and gender pay gaps, and ensuring that immigrants have access to lawful employment and benefits.



## REFERENCES

- 1 "Latinx" is a term that challenges the gender binary in the Spanish language and embraces the diversity of genders that often are actively erased from spaces. Due to the limitations of data collection, we use "Latina(s)" or "women" where research only shows findings for cisgender women, including Latinas.
- 2 In 1978, Congress added two exceptions—pregnancies resulting from "promptly reported" rape and incest and certification from two physicians that the pregnancy would cause "severe and long-lasting physical health damage." However, Congress again removed the "physical health danger" exception in 1979 and the rape and incest exceptions in 1981. This total ban version of the Hyde Amendment remained in place until 1993, when President Clinton and Congress introduced a budget that removed the Hyde Amendment. Representative Hyde reintroduced the amendment but included the rape and incest exceptions as a "compromise." In 1997, the Hyde Amendment was modified yet again. At that point, Congress restricted the life endangerment exception to "a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed." Allina, *How Restrictions on Abortion Coverage*, 2-3.
- 3 All Above All, *Hyde Amendment Fact Sheet*, All Above All (Sept. 26, 2017), <https://allaboveall.org/resource/hyde-amendment-fact-sheet/>.
- 4 See Guttmacher Institute, *Medicaid Funding of Abortion*, Guttmacher Institute (Feb. 2018), <https://www.guttmacher.org/evidence-you-can-use/medicaid-funding-abortion> (including Alaska, Arizona, California, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, New York, Oregon, Vermont, Washington, West Virginia).
- 5 *Id.*
- 6 *Id.*
- 7 U.S. Census Bureau, *Decennial Census of Population and Housing* (2010).
- 8 *Supra* note 4.
- 9 Guttmacher Institute, *Abortion Rates by Race and Ethnicity*, Guttmacher Institute (Oct. 19, 2017), <https://www.guttmacher.org/infographic/2017/abortion-rates-race-and-ethnicity>.
- 10 *Supra* note 4 ("Women of color are more likely than white women to be low-income and to be enrolled in Medicaid. In 2015, 31% of black women and 27% of Hispanic women aged 15-44 were enrolled in Medicaid, compared with 16% of white women").
- 11 *Id.*
- 12 S. Ruggles, K. Genadek, R. Goeken, J. Grover, M. Sobek, *Integrated Public Use Microdata Series*, Minneapolis: University of Minnesota (Mar. 16, 2017), <https://usa.ipums.org/usa/>.
- 13 Artiga, Samantha et al., *Medicaid and American Indians and Alaska Natives*, Kaiser Family Foundation (2017), <http://files.kkf.org/attachment/issue-brief-medicaid-and-american-indians-and-alaska-natives>.
- 14 National Women's Law Center, *National Snapshot: Poverty Among Women and Families*, National Women's Law Center (Sept. 2015), <http://nwlc.org/wp-content/uploads/2015/08/povertysnapshot2014.pdf>.
- 15 All Above All, *The Impact of Out-of-Pocket Costs on Abortion Care Access*, Ibis Reproductive Health (Sept. 2016), <https://allaboveall.org/wp/wp-content/uploads/2016/09/OutOfPocket-Impact.pdf>.
- 16 *Id.*
- 17 *Id.*
- 18 Elizabeth Nash, Rachel B. Gold, Lizamarie Mohammed, Zohra Ansari-Thomas, and Olivia Cappello, *Policy Trends in the State*, 2017, Guttmacher Institute (Jan. 2, 2018), <https://www.guttmacher.org/article/2018/01/policy-trends-states-2017>.
- 19 *Id.*
- 20 Center for Reproductive Rights, *Abortion Clinic Shutdown Cases at The Supreme Court*, Center for Reproductive Rights (2016), <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/SCOTUS-Media-Kit-04-26-2016.pdf>.