Leveraging the Tools Available: Using the Hyde Amendment to Preserve Minimum Abortion Access and Mitigate Harms in Restrictive States

Fabiola Carrión,[1]
Lee Hasselbacher,[2]
and Terri-Ann Thompson[3]

1: NATIONAL HEALTH LAW PROGRAM, LOS ANGELES, CA, USA, 2: UNIVERSITY OF CHICAGO, CHICAGO, IL, USA, 3: IBIS REPRODUCTIVE HEALTH, CAMBRIDGE, MA, USA.

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Abstract: The overturn of *Roe v. Wade* has resulted in fewer rights and resources for people seeking abortion care, particularly in the South. The Hyde Amendment has historically restricted abortion access for those enrolled in Medicaid. We argue here that its guarantees of minimum abortion coverage should be leveraged to offset harms where possible.

On June 24, 2022, the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* overturned *Roe v. Wade*, which guaranteed a constitutional right to access abortion.[1] This commentary aims to describe how, even before *Dobbs*, abortion restrictions — and particularly the Hyde Amendment[2] — created disproportionate harms for pregnant people of color. These harms have already worsened in the new legal landscape, particularly in the Midwest and South. Currently, abortion is banned before 6 weeks' gestation in 16 states — 11 of which create an abortion desert in the South stretching from Texas to South Carolina, as far north as Kentucky and West Virginia.[3] A recent national report collecting data from clinics finds that restrictions in these 11 Southern states disrupted abortion access for 71,830 people in the nine months following the Dobbs decision.[4] The Hyde Amendment limits the use of federal funds for abortion, including through Medicaid, but it also establishes that the federal government must pay for abortions in the case of rape, incest, and life endangerment of the pregnant individual. If Congress lacks the political will to repeal the Hyde Amendment and pass the Equal Access to Abortion Coverage in Health Insurance Act (EACH Act),[5] we argue that abortion providers in restrictive states should still seek reimbursement as allowed by the Medicaid Act.

Fabiola Carrión, J.D., *is the Director, Reproductive and Sexual Health at the National Health Law Program;* **Lee Hasselbacher, J.D.,** *is a Research Assistant Professor and Faculty Director of the Center for Interdisciplinary Inquiry and Innovation in Sexual and Reproductive Health (Ci3) at The University of Chicago;* **Terri-Ann Thompson, Ph.D.,** *is a Senior Research Scientist at Ibis Reproductive Health.*

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Decades of Abortion Restrictions Created Obstacles to Care, Including the Hyde Amendment

Even before *Dobbs*, states introduced laws that falsely purported to protect people seeking abortion, enshrined fetal personhood, and isolated abortion care from the larger health care system, all without explicitly banning all abortion.[6] Many of these laws survived litigation, which then subjected clinics to unnecessary and onerous facility standards, provider licensing requirements, and other targeted regulations of abortion provider laws ("TRAP laws"). Over the years, laws also mandated lower gestational limits for abortion, restrictions on medically safe procedures, limits on use of telehealth, long waiting periods, and restrictions on minors' access to abortion.[7] Several states also banned abortion coverage in private insurance.[8]

Among these restrictions, however, few were as clearly designed to obstruct and penalize people with low incomes as the Hyde Amendment, which is a rider attached to the federal appropriations bill each year. First introduced in 1976, Congress has voted to renew the Hyde Amendment each budget cycle. Hyde limits the Department of Health and Human Services (HHS) from using federal funding to pay for abortion except in cases of rape, incest, and life endangerment.[9] To understand the scale of this restriction: before the Hyde Amendment, around 300,000 abortions were covered by Medicaid each year, which equaled roughly 24% of abortions at the time.[10] Currently, 42% of births are covered by Medicaid and states with the highest percentage of births covered by Medicaid (47%-61%) have the most abortion restrictions and are largely in the South — including South Carolina, Georgia, Alabama, Mississippi, Louisiana, Tennessee, Kentucky, West Virginia, Oklahoma, and Texas.[11] Experts estimate there are 7.8 million women aged 15-49 enrolled in Medicaid without abortion coverage and half are women of color.[12] The Hyde Amendment withstood a legal challenge in *Harris v. McRae* in 1980.[13] Despite acknowledging that Congress "opted to subsidize medically necessary services generally" through Medicaid, "but not certain medically necessary abortions," the Supreme Court found the restriction constitutional because "the financial constraints that restrict an indigent woman's ability to enjoy the [full right to abortion] are the product not of government restrictions on access to abortions, but rather her indigency."[14]

The Hyde Amendment Disproportionately Harms Black, Indigenous, and Other Pregnant People of Color

Prior to *Dobbs*, 61% of abortion seekers identified as a race other than White (Black, Hispanic, Asian or Pacific islander, or some other race or ethnicity).[15] Economic disadvantage is at the root of observed disparities in unintended pregnancy and abortion as: 1) unintended pregnancies are highest among women with low incomes,[16] 2) 75% of abortion seekers are poor and low income,[17] and 3) the highest rates of poverty are experienced by women of color.[18] As such, finance is a significant lever by which abortion inequities can be exacerbated or reduced.

Two recent studies, one with women recruited from prenatal care clinics,[19] the other with women recruited through Google Ads,[20] found that economic insecurity was among the reasons that many who considered getting an abortion would ultimately not obtain one. Safety net systems such as Medicaid were established to guard against this consequence — ensuring that people, irrespective of income, have access to essential healthcare services. However, policies such as the Hyde Amendment constrain the benefits of the program by design — restricting the use of public funds to cover abortion. While some states have decided to cover abortion care with state funds for Medicaid beneficiaries, most have not.[21]

The Hyde Amendment limits the use of federal funds for abortion, including through Medicaid, but it also establishes that the federal government must pay for abortions in the case of rape, incest, and life endangerment of the pregnant individual. If Congress lacks the political will to repeal the Hyde Amendment and pass the Equal Access to Abortion Coverage in Health Insurance Act (EACH Act), we argue that abortion providers in restrictive states should still seek reimbursement as allowed by the Medicaid Act.

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Among Medicaid-qualified women who seek an abortion, 1 in 4 will carry an undesired pregnancy to term because the abortion is not covered.[22] Lack of Medicaid coverage for abortion care creates additional challenges for abortion seekers by increasing out-of-pocket costs, delaying care, and placing some in a position of having to delay or forgo payment for basic necessities such as rent, food, or utilities.[23] Because a disproportionate number of Black, Indigenous, and other people of color (BIPOC) are insured by Medicaid, the impact of the Hyde Amendment is more greatly felt by this community. Furthermore, a significant proportion of the BIPOC U.S. population resides in the South (59% of the Black population and large proportions of the Hispanic, Native American, and Asian population),[24] and most of those states (16/17) do not extend Medicaid coverage for abortion beyond the Hyde Amendment.[25]

The vast majority of abortions occur during the first trimester.[26] However, given increasing patient costs for first trimester abortion care (at least $560 for a medication abortion and $575 for a first trimester procedural abortion),[27] and the fact that 1 in 3 U.S. residents cannot pay for a $400 emergency expense using savings from their bank or checking account,[28] increasing numbers of low-income and BIPOC patients will need to seek assistance from the finite resources of abortion funds.[29]

Finally, while focus on the Hyde Amendment has been limited to its effect on abortion access, the Hyde Amendment in concert with other abortion restrictions has a negative impact on other public health outcomes of particular importance to the BIPOC community. Principles of reproductive justice — enumerated by Black women leaders in 1994 — call for the right to maintain personal bodily autonomy, have children, not have children, and parent children in safe and sustainable communities.[30] To achieve reproductive justice, policies must equally support healthy pregnancies, family planning, and access to abortion. For instance, new studies have highlighted an association between maternal mortality and abortion restrictions (including coverage restrictions).[31] These studies suggest that states that restrict abortion or have a high abortion policy composite score (five or more abortion restrictions in place) have higher maternal mortality than states with lower abortion policy composite scores or who are neutral or protective towards abortion.[32] Additionally, one study found greater odds of mortality for Black infants born in states with Medicaid restrictions compared with those born in states with no restrictions.[33] In light of these findings and the fact that BIPOC women experience maternal mortality at rates 2-3 times higher than their White counterparts (of the ten states with the highest maternal mortality rate, six are in the South),[34] strategies that reduce reproductive health disparities must include removing financial barriers to abortion care.

Can the Hyde Amendment Preserve Minimal Access?

When it comes to public insurance coverage, questions arise whether states with restrictions must still allow for abortion care within the circumstances mandated by the Hyde Amendment. For instance, the federal government has made abortion available in any state, to those participating in the Veteran's Health Administration (VA) under the same Hyde Amendment exceptions.[35] We argue that, at the very least, abortion providers should seek reimbursement for Medicaid-eligible abortions under the circumstances allowed by state law.

Title XIX of the Social Security Act, which creates the Medicaid program, authorizes annual monetary appropriations set by Congress to fund the federal government's portion of specific Medicaid services.[36] The Hyde Amendment modifies the requirement that Medicaid program pay for medically necessary care, which would include abortions beyond the circumstance of rape, incest, and when the life of the pregnant person is endangered. Two State Medicaid Director (SMD) Letters from 1994 and 1998 (subregulatory guidance issued by the Centers for Medicare and Medicaid Services) confirmed that states must "comport with the current statutory language."[37] States are obliged to at least comply with the Hyde Amendment, and they can cover more care with their own money. Case law reinforced that participating Medicaid states must fund those abortions for which federal reimbursement is available.[38] For example, the Tenth Circuit explicitly concluded, "the Secretary of Health and Human Services *is owed deference* regarding her interpretation of the Hyde Amendment mandates" (emphasis added).[39] In various documents issued over the last four decades, HHS has held that abortions that fall under the Hyde Amendment are mandatory and "medically necessary" services to be covered under the Medicaid Act.[40] Circuit courts, including those covering Southern states, have held that states participating in Medicaid must fund "medically necessary abortions."[41]

Courts have examined whether the Hyde Amendment, as an appropriations bill rider, creates an obligation on states since it is not a permanent statute. Most of them have concluded that the Hyde Amendment, as an extension of the Medicaid Act, has preemptive effect for conflicting state laws.[42] They have found that because the Hyde Amendment is a revision or modification to the Medicaid Act, states are bound to fol-

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low it. For instance, the Sixth Circuit declared that the Hyde Amendment is not "*simply a federal appropriations bill*; rather, it defines medically necessary abortions that must be funded by the federal government and by participating states" (emphasis added).[43] At minimum, abortions should be covered under the circumstances allowed by federal and state law. We therefore argue that the Hyde Amendment coverage obligations should be interpreted as a requirement to allow those enrolled in Medicaid to access covered abortion care when it aligns with Hyde restrictions and state abortion law. For this to happen, advocates should push for HHS to issue regulatory guidance — such as SMDs — to ensure that abortion providers can still receive reimbursement under the restrictive circumstances.

Conclusion

The *Dobbs* decision has left the country, particularly pregnancy-capable people and health care providers in the South, in complete chaos.[44] Over the course of several years, advocates, scholars, and policymakers will have to address and attempt to solve the myriad legal complexities that are unfolding. However, as long as it exists, state Medicaid agencies must comply with the Medicaid Act and, by extension, the Hyde Amendment. Sustaining abortion coverage where possible, in the places where it is most needed, will ensure that at least some people get the care they need without having to make financial tradeoffs that risk their financial and general wellbeing.[45] It is important to note that the Hyde Amendment has not been, is not, and will never be the optimal solution for Medicaid beneficiaries and that advocating for its enforcement is paradoxical and suboptimal. As abortion advocates confront the post-*Dobbs* world, getting rid of the Hyde Amendment and passing federal laws, like the EACH Act, are key steps to making abortion truly accessible and aligned with the principles of abortion care.

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