GUTTMACHER INSTITUTE

February 10, 2011

The Honorable Jerrold Nadler, Ranking Member
Judiciary Subcommittee on the Constitution
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Nadler:

Thank you for the opportunity to submit this statement on behalf of the Guttmacher Institute in opposition to H.R. 3, the No Taxpayer Funding for Abortion Act, on which a hearing was held before the Subcommittee on the Constitution on February 8, 2011.

Through its work as an independent, not-for-profit organization focusing on reproductive health research, policy analysis and public education in the United States and internationally, the Guttmacher Institute has developed and analyzed a great deal of information on public- and private-sector abortion insurance coverage, the implications for the health and well-being of women and their families of insurance coverage or the lack thereof, and the relationship between insurance coverage and abortion incidence. Many of the Institute's research findings, along with key research findings of other experts in the field, are addressed in two articles directly relevant to H.R. 3 from the *Guttmacher Policy Review* that are summarized below and attached for inclusion in the record.

A primary purpose of H.R. 3 is to write into permanent law an annually imposed policy, commonly referred to as the Hyde amendment, that sharply limits abortion coverage (currently to cases of life endangerment, rape and incest) under Medicaid, the joint federal-state health insurance program for the nation's lowest-income citizens. H.R. 3 would also make permanent the Hyde amendment's so-called progeny, a series of policies that similarly restrict abortion coverage or services for other groups of women dependent on the government for their health insurance or health care, ranging from women in federal prisons to women in the U.S. armed forces.

As discussed in "The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States" (Winter 2007), a number of studies conducted over the last three decades have assessed the impact of the Hyde amendment's near-ban on Medicaid insurance coverage of abortion. A review of these studies published by the Institute in 2009 concluded that some three in four poor women seeking an abortion manage to obtain one notwithstanding the lack of coverage. This may be a testament to their determination not to bear a child they feel unprepared to care for, but their doing so also may come at a considerable price to themselves and their families. Various studies indicate that many Medicaid enrollees denied abortion coverage are forced to divert money meant for rent, utility bills, or food or clothing for themselves and their children as they scrape together the funds to pay for the procedure. This is especially problematic because both the cost and the risk of an abortion increase as a pregnancy continues. In 2009, the average charge for an abortion was $451 at 10 weeks' gestation, but it jumped to $1,500 at 20 weeks. And the risk of death from abortion, although exceedingly small at any point, increases exponentially with gestational age. Thus, a poor woman seeking an abortion in the absence of Medicaid coverage is

often caught in a vicious cycle: the longer it takes for her to obtain the procedure, the harder it is for her to afford it, even as the risk to her health is increased. And, of course, one in four Medicaid enrollees who would have an abortion if Medicaid coverage were available is unable to do so and carries her unwanted pregnancy to term.

I would like to address a point on which Guttmacher research is frequently invoked and misrepresented. It simply does not follow that because one in four Medicaid enrollees who would have an abortion if it were covered under Medicaid is unable to do so in the absence of such coverage, restoration of federal Medicaid coverage would result in a significant increase in the incidence of abortion nationwide. As discussed in "Insurance Coverage and Abortion Incidence: Information and Misinformation" (Fall 2010), this is because only a small proportion of women are enrolled in Medicaid in any state, and because 17 states, including several of the nation's most populous, are among those that use their own money to pay for abortion services for poor women. Accordingly, lifting the Medicaid restrictions would translate into an estimated 5% rise in the total number of abortions in the group of states in which funding is currently restricted—and a 2.5% increase in the total number of abortions performed nationwide.

In conclusion, the Hyde amendment endangers poor women's reproductive health and violates their reproductive and human rights. Even the five-member majority opinion in the 1980 Supreme Court decision upholding Congress' ability to impose the Hyde amendment took pains to stress that the Court was not passing judgment on the merits of the funding restriction by deciding "whether the balance of competing interests reflected in the Hyde Amendment is wise social policy." On the contrary, said the Court, "if that were our mission, not every Justice who has subscribed to the judgment of the Court today could have done so." Indeed, the Hyde amendment is *not* wise social policy. Instead of enshrining the Hyde amendment in permanent federal law, Congress should be acting to repeal it—as it should be acting to repeal its progeny, the range of restrictive policies that similarly deny abortion coverage or services to various groups of women who are dependent on the federal government for their health insurance or health care.

Finally, it should go without saying that Congress should not be extending the harms of the Hyde amendment and its progeny further by seeking, as H.R. 3 does under the disingenuous "no taxpayer funding" label, to eliminate abortion coverage in what heretofore has always been considered the private insurance market by redefining "taxpayer funding" to encompass the standard tax treatment currently afforded to individual or employer-based health insurance plans should those plans include abortion coverage. Abortion is a legal, constitutionally protected and medically appropriate health care service that fully merits health insurance coverage, both in private-sector plans and in plans for those dependent on the federal government.

Thank you for the opportunity to provide these comments.

Sincerely,

Cory L. Richards
Executive Vice President
and Vice President for Public Policy

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The Heart of the Matter: Public Funding Of Abortion for Poor Women in the United States

By Heather D. Boonstra

This year marks the 34th anniversary of *Roe v. Wade,* the landmark U.S. Supreme Court decision that provided constitutional protection for abortion. In its 7-2 ruling, the Supreme Court recognized a woman's constitutional right to decide, in consultation with her physician, whether to terminate a pregnancy. This year also marks the 30th anniversary of the implementation of the Hyde Amendment, which bans federal funding for abortion in all but the most extreme circumstances. Named after longtime Rep. Henry Hyde (R-IL), who retired in 2006, the measure primarily affects Medicaid, the joint federal-state program that finances the provision of health services to eligible Americans deemed too poor to afford care on their own. More than seven million women of reproductive age—12% of all U.S. women in that age-group—are enrolled in the Medicaid program.

Medicaid enrollees are the poorest of poor Americans. For a woman to qualify, she must have an income below the very low eligibility ceiling set by her state. State income eligibility ceilings range as low as 18% of the federal poverty level in Arkansas and average 65% of poverty. That average translates to an annual income of $11,160, or roughly $930 per month for a family of three. Nearly four in 10 poor women of reproductive age are covered under Medicaid (related article, page 24). Most of these women are either pregnant or already a parent, as childless adults are typically ineligible at any income. As the average cost of an abortion at 10 weeks' gestation is $370, a poor woman with children who decides to have an abortion is likely to have very little left to survive on that month.

Poor women have been pawns in the congressional debate over abortion since the procedure became legal nationwide. For opponents of abortion, public funding has been a proxy for overturning *Roe.* As Hyde 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 vehicle available is the…Medicaid bill." For prochoice leaders, on the other hand, public funding was a matter of fundamental fairness and equal protection under the law. "If we now restrict or ban Medicaid funding for abortions, the government will accomplish for poor women indirectly what the 1973 [Supreme Court] opinion expressly forbade it to do directly…a right without access is no right at all," said then-Sen. Edward Brooke (R-MA), speaking in opposition to the Hyde Amendment during one of the early congressional debates.

Three Decades of Restrictions

It may be hard to believe today, but public funding of abortion was hotly debated and threatened to shut the government down more than once in the 1970s. Annual debates were intense and protracted, with dozens of votes and innumerable hours spent arguing over the respective merits or demerits of the words "serious" versus "severe," "permanent" versus "long-lasting," "forced rape" versus "rape." The first version of the Hyde Amendment passed under election-year pressure in 1976, only to be reopened the following year. In December 1977, after a months-long, paralyzing debate in Congress—during which the Senate sought to liberalize the Hyde

Amendment to cover all "medically necessary" abortions, while the House tried to prohibit public funding for abortion in any circumstance—a compromise was reached that permitted the federal government to pay its share of the cost of abortions for women enrolled in Medicaid only in cases where their lives were threatened, where two doctors certified that continuation of the pregnancy would result in "severe and long-lasting" physical health damage, or where rape or incest had been reported. Most observers at the time thought this compromise would stick, at least for the near future, but in 1979, the limited physical health exception was dropped, followed by the rape and incest exceptions in 1981.

In June 1980, the Supreme Court upheld the constitutionality of congressional restrictions on abortion funding in *Harris v. McRae*. The court ruled that the Hyde Amendment did not violate the due process and equal protection clauses of the Constitution, declaring that "a woman's freedom of choice [does not carry] with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices." The federal government could choose to encourage childbirth over abortion by paying for the former and not the latter—even if to do so might not be "wise social policy." According to the Court, because the government did not cause women to be poor, it is not obligated to level the playing field for poor women: "Although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation, and indigency falls within the latter category."

Following the Supreme Court ruling, and with Presidents Reagan and Bush in power during the 1980s, the Hyde Amendment essentially became a political nonissue. It was not until President Clinton took office in 1993 that poor women were on the agenda again. Prochoice forces in Congress fought hard to expand coverage to once again include cases of rape and incest, which they saw at the time as the first incremental step toward the long-term goal of an expanded Medicaid policy. That goal was dashed for the foreseeable future, however, when the Republicans, complete with a determined antiabortion leadership under Newt Gingrich (R-GA), gained control of the House in 1994.

The current version of the Hyde Amendment, established in 1997, allows federal funding for abortion in cases of rape and incest, as well as life endangerment, but tightens the life exception to permit payment only when the woman's life is threatened by "physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself." (At the state level, 17 states currently have a policy to use their own funds to pay for all or most medically necessary abortions sought by Medicaid recipients; see table.) In

CHOICE DENIED

Although some states use their own funds to pay for medically necessary abortions for poor women enrolled in Medicaid, most states follow the restrictive federal standard.

Funds Abortions in Cases of Life Endangerment, Rape or Incest	Funds All or Most Medically Necessary Abortions
Alabama	Alaska
Arkansas	Arizona
Colorado	California
Delaware	Connecticut
District of Columbia	Hawaii
Florida	Illinois
Georgia	Maryland
Idaho	Massachusetts
Indiana†	Minnesota
Iowa§	Montana
Kansas	New Jersey
Kentucky	New Mexico
Louisiana	New York
Maine	Oregon
Michigan	Vermont
Mississippi§	Washington
Missouri	West Virginia
Nebraska	
Nevada	
New Hampshire	
North Carolina	
North Dakota	
Ohio	
Oklahoma	
Pennsylvania	
Rhode Island	
South Carolina	
South Dakota*	
Tennessee	
Texas	
Utah†§	
Virginia§	
Wisconsin†	
Wyoming	
33 + DC	**17**

*Only covers abortions when necessary to protect the woman's life. †Covers those abortions necessary to avoid grave, long-lasting damage to the woman's physical health. §Covers abortions related to fetal abnormality.

addition, over the years, Congress has enacted legislation essentially banning abortion funding for other large groups of Americans dependent on the federal government for their health care or health insurance, ranging from federal employees and military personnel to women in federal prisons and low-income residents of the District of Columbia (see box).

The Impact

Researchers have studied the impact of funding restrictions on women's reproductive decisions and have found that despite the relatively high cost of the procedure, most poor women in need of an abortion manage to obtain one—a testament to women's determination not to bear a child they feel unprepared to care for. But their doing so often comes at a cost, as many poor women have to postpone their abortion. For those who are affected, the delay is substantial: Poor women take up to three weeks longer than other women to obtain an abortion. Little wonder that, according to a 2004 Guttmacher study published in *Contraception,* 67% of poor women having an abortion say they would have preferred to have had the abortion earlier.

Research indicates that women who are economi-

Additional Federal Restrictions on Abortion Funding

Over the past two decades, Congress has enacted bans similar to the Hyde Amendment (repeatedly as part of the annual appropriations process or within permanent law) that together affect millions of women who depend on the federal government for their health care.

Military Personnel and Their Dependents

• TRICARE (formerly the Civilian Health and Medical Program of the Uniformed Services) is the military health care system serving 6.9 million active duty military personnel, retired personnel and members of their families. Data on the number of female enrollees are unavailable, but TRICARE is open to 212,000 women of reproductive age currently serving in uniform and 1.6 million female veterans, more than 80% of whom are younger than 65.

• Since 1979, the Department of Defense has prohibited abortion funding for military personnel, retirees and their dependents through TRICARE except when a woman's life is in danger. In 1985, the ban was made permanent. In 1997, Congress went even further by prohibiting the performance of abortions in military hospitals overseas even if paid for privately, except in cases of rape, incest or where the woman's life would be at risk.

• For the half million men and women in uniform who are stationed overseas, the imposition of abortion restrictions is doubly unfair. The denial of abortion services is not only costly, but for many, military health facilities are the only source of safe, high-quality health care, particularly where abortion is illegal. Because they cannot obtain an abortion in a military hospital even if they paid for it themselves, the only options for many are to make expensive arrangements to obtain a medically safe abortion in another country or risk unsafe conditions in-country.

Federal Employees and Their Dependents

• The Federal Employees Health Benefits Program (FEHBP) is the largest employer-sponsored health insurance program in the nation, currently covering nine million federal employees and dependents. Over one million women are currently employed as part of the federal workforce, the vast majority of whom make less than $40,000 per year.

• In 1983, Congress imposed a ban on FEHBP funds from being used to pay for insurance plans that cover abortion, except where a woman's life is in jeopardy. After a brief two-year hiatus, a slightly less restrictive policy was reimposed in 1996. Currently, FEHBP funds cannot be used to pay for insurance coverage of abortion, except in cases of life endangerment, rape or incest.

American Indians and Alaskan Natives

• The Indian Health Service (IHS) comprises more than 142 clinics and health care facilities that provide medical care to 1.8 million American Indians and Alaskan Natives, 918,000 of whom are women. The median age of Native Americans within the

cally disadvantaged are delayed at two key stages. Poor women typically take more time than better-off women to confirm a suspected pregnancy, which could be because of the cost of a home pregnancy test or the difficulty in getting a test from a clinic or doctor. In addition, they take several more days between making the decision to have an abortion and actually obtaining one. When asked why they were delayed at this stage, poor women are about twice as likely as more affluent women (after controlling for other personal characteristics) to report having difficulties in arranging an abortion, usually because of the time needed to come up with the money.

Moreover, other research shows that poor women who are able to raise the money needed for an abortion often do so at great sacrifice to themselves and their families. Studies indicate that many such women are forced to divert money meant for rent, utility bills, food or clothing for themselves and their children.

One reason why delays in obtaining an abortion are important is because the cost and the risk of a procedure increases with gestational age. In 2001, the average charge for an abortion in 2001 was $370 at 10 weeks' gestation, but jumped to $650 at 14 weeks and $1,042 at 20 weeks. Thus,

United States is 29, a full seven years younger than for American citizens overall. Native Americans are less likely than other Americans to have health insurance and are twice as likely to have incomes below the poverty line. IHS-supported health care is the only source of care for most American Indians.

• Before 1996, the IHS only covered abortions in cases of life endangerment; since that time, its abortion policy has been brought into alignment with the Hyde Amendment to include exemptions for rape or incest as well.

Poor Women in the District of Colombia

• Some 27,000 women in the District of Colombia depend on Medicaid for their health care. To qualify for Medicaid, women who are working parents must have an income below 207% of the federal poverty level (roughly $35,540 for a family of three in 2007).

• Because Congress has ultimate authority over all District government spending and operations, Congress has been able to bar the District from using locally raised revenues for abortion, except in cases involving life, rape or incest, a policy which has been in place since 1989.

Women in Federal Prisons

• No group of women is more restricted in their health care choices than those in correctional facilities. There are more than 12,000 women serving time in federal prisons—a population that is increasing at the rate of 4.6% per year. Approximately 80% of women in U.S. correctional facilities are aged 18–44.

• Since 1987, the Department of Justice has been prohibited from paying for abortions for women in federal prisons, except in cases of life endangerment or rape. A female inmate who can afford to pay for an abortion may obtain one outside the prison using private funds; under these circumstances, she must be provided an escort at no cost. However, a "conscience" provision allowing workers in federal prisons to refuse to serve as an escort was added in 1989.

Peace Corps Volunteers

• The vast majority of the nation's nearly 8,000 Peace Corps volunteers serve in developing countries where safe and reliable health care is a rare luxury. Close to 5,000 are women, mostly unmarried and young (average age, 28 years). Peace Corps volunteers receive only modest monthly stipends meant to cover the cost of living and little more.

• Peace Corps volunteers are denied a federally subsidized abortion even when their lives are at risk. Since 1979, Congress has prohibited funding of abortions for any reasons. For many female Peace Corps volunteers experiencing an unintended pregnancy, a medically safe abortion may be many thousands of miles and dollars away.

—Casey Alrich and Heather D. Boonstra

the longer it takes for poor women to obtain an abortion, the harder it is for them to afford it. In addition, the risk of complications increases exponentially at higher gestations, so many poor women become trapped in a vicious cycle in which their difficulties are exacerbated and their health risks increased.

Notably, a poor woman's access to a timely abortion depends on the policy in her state. According to the 2004 Guttmacher study, which looked at women obtaining abortion in 11 states, poor women living in states that use their own funds to pay for all or most medically necessary abortions obtain the procedure nearly a week earlier than women in the same states whose incomes are 100–149% of the poverty level, which are typically too high for Medicaid. By contrast, in states that restrict the use of funds for abortion, poor and near-poor women have their abortion at about the same gestation.

Perhaps the most tragic result of the funding restrictions, however, is that a significant number of women who would have had an abortion had it been paid for by Medicaid instead end up continuing their pregnancy. A number of studies have examined how many women are forced to forgo their right to abortion and bear children they did not intend. Studies published over the course of two decades looking at a number of states concluded that 18–35% of women who would have had an abortion continued their pregnancies after Medicaid funding was cut off. According to Stanley Henshaw, a Guttmacher Institute senior fellow and one of the nation's preeminent abortion researchers, the best such study, which was published in the *Journal of Health Economics* in 1999, examined abortion and birthrates in North Carolina, where the legislature created a special fund to pay for abortions for poor women. In several instances between 1978 and 1993, the fund was exhausted before the end of the fiscal year, so financial support was unavailable to women whose pregnancies occurred after that point. The researchers concluded that about one-third of women who would have had an abortion if support were available carried their pregnancies to term when the abortion fund was unavailable.

The Future

Most prochoice advocates would probably agree that today, just as in the late 1970s when annual battles raged in Congress for months at a time, the issue of Medicaid funding for poor women goes to the heart of who has access to abortion in this country and under what circumstances. Led by Speaker Nancy Pelosi (D-CA), the House leadership is now firmly supportive of abortion rights and access, even for poor women, and there is in all likelihood a prochoice majority, however slim, in the Senate. Yet the issue of public funding is not on the table, and it is not likely to be in the near-term future. Democratic majorities in the House and Senate are fragile, and party leaders, who have made it clear that they intend to govern "from the center," are unlikely to volunteer to take up such an inherently controversial issue anytime soon. Even many national prochoice leaders would argue that, with a president hostile to abortion rights and states like South Dakota passing abortion bans aimed at forcing an increasingly conservative Supreme Court to reconsider its fundamental abortion rulings, this is not the optimal time to force a reopening of the funding question.

Long stymied at the federal level, supporters of abortion funding have turned with some optimism to the states to jumpstart the movement. An impatient network of prochoice activists, spearheaded by the National Network of Abortion Funds, has teamed up to launch a public education campaign. The campaign, *Hyde—30 Years Is Enough!,* has been endorsed by the major national organizations and is thought to have a real chance of paying off in at least one state this year. Legislators in Maine are poised to debate whether that state should become the 18th in the nation to use its own funds to subsidize abortions for its Medicaid enrollees. It is to be hoped that Maine's campaign will be successful, and that it will be the first step in an accelerating, albeit undeniably uphill, campaign on behalf of the nation's poor women and a critical component of their overall reproductive health and rights. www.guttmacher.org

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Insurance Coverage and Abortion Incidence: Information and Misinformation

By Rachel Benson Gold

With a grim inevitability, the issue of restrictions on insurance coverage for abortion moved to center stage as the congressional health care reform debate came to a head in the fall of 2009. What was less predictable, perhaps, was that abortion opponents would misuse Guttmacher Institute research to bolster their assertion that anything short of a flat ban on coverage of the procedure would somehow greatly increase the number of abortions taking place in the United States. According to Richard Land of the Southern Baptist Convention, enactment of the Senate version of the measure—notwithstanding its stringent abortion coverage restrictions—would "lead, as some experts project, to a 30 percent increase in abortions in America. This legislation, if passed, will be the largest expansion of abortion since the *Roe v. Wade* decision in 1973."

The Senate bill was, in fact, enacted into law in March 2010 with its abortion restrictions intact (related article, page 2). Since then, however, a vastly overstated link between insurance coverage and abortion incidence—and the misuse of Guttmacher data to support it—has repeatedly been alleged at the state level, including as a prominent feature of model legislation drafted for state legislators by the antiabortion advocacy organization Americans United for Life. The Federal Abortion-Mandate Opt-Out Act, which would block coverage of abortion in the health insurance exchanges to be set up by states, asserts that the Guttmacher Institute "confirms that, based on Medicaid studies, more women have abortions when it is covered by private or public insurance programs."

The referenced Guttmacher "Medicaid studies" do indeed conclude that denial of abortion insurance coverage in the form of Medicaid funding impedes a sizable minority of America's poorest women from obtaining the procedure—and that restoration of coverage would result in an increase in abortion incidence among this population. However, the claim that restoration of federal Medicaid coverage would result in a significant increase in the incidence of abortion nationwide is not supported by the research, and extrapolating from Guttmacher's Medicaid findings to assert that coverage in the private insurance market is strongly linked to abortion incidence is entirely illegitimate.

This is by no means to say that the question of abortion insurance coverage is not important. Even if coverage may not determine whether most women actually obtain a procedure, it may have a major impact on the circumstances under which they do so and on the perception of abortion as a legitimate health care service. And on these matters, partisans on opposite sides of the abortion debate have sharply different views of what the situation ought to be.

Publicly Funded Abortions

Restrictions in place for more than three decades—measures often collectively referred to as the Hyde amendment for their original sponsor, former Rep. Henry Hyde (R-IL)—have sharply limited the use of federal Medicaid funds for abortion services for low-income women, currently to cases of life endangerment, rape and incest. Under the Hyde amendment, states may use their own funds to pay for abortions for

their Medicaid enrollees, and 17 states and the District of Columbia do so.

Claims of a strong link between abortion coverage and abortion incidence—both among the population of Medicaid enrollees and among the population at large—purport to be based on studies in five states (Georgia, Illinois, North Carolina, Ohio and Texas) in which neither federal nor state funds for abortion were available. These studies generally looked at what happened when Medicaid funding restrictions were first implemented some three decades ago and found that approximately one in four women who would have had a Medicaid-funded procedure if funds had been available were unable to do so.

By maintaining the Hyde amendment, health care reform represents the largest expansion of abortion funding restrictions since Hyde was first implemented.

Guttmacher Institute researchers—looking not at the past but contemporaneously at differences between states that are now using state dollars to fund abortions for low-income women and states where funding is restricted—nonetheless found a strikingly similar result. In an unpublished analysis presented at a scientific conference of demographers and statisticians in 2007, Guttmacher researchers compared the abortion rate (number of abortions per 1,000 women 15–44) among female Medicaid enrollees in funding states with that among Medicaid enrollees in nonfunding states. From the differences between the abortion rates for Medicaid enrollees in these two groups of states, the researchers concluded that restoring funding would result in a 28% increase among Medicaid enrollees in states where funding is currently restricted.

But making the leap from a finding that restrictions on public funding make abortion unattainable for about one in four women poor enough to be on Medicaid to the assertion that repealing the Hyde amendment would significantly increase the total abortion rate in those states, let alone in the United States as a whole, is entirely unsupportable. This is because only a small proportion of women are poor enough to be enrolled in Medicaid and therefore affected by the restrictions. In fact, according to the Guttmacher analysis, lifting the funding restrictions would translate into only a 5% rise in the total number of abortions in the group of states in which funding is currently restricted. (Nationwide, only 15% of women of reproductive age are covered by Medicaid; related article, page 17.)

And because several of the nation's most populous states, such as California and New York, are among those that use their own money to pay for abortion services for poor women, the national impact of repealing the Hyde amendment would be even smaller: According to the comparison of abortion rates among Medicaid enrollees in funding and in nonfunding states, the number of abortions among Medicaid-eligible women nationwide would be expected to rise by approximately 33,000 if the Hyde amendment were to be repealed—only a 2.5% increase in the total number of abortions performed nationwide.

In sum, two sets of research yield evidence that could be used to get a sense of the potential impact of repealing the Hyde amendment. The oldest studies, conducted at a time when Medicaid eligibility was much more restrictive than it is today (averaging 45% of poverty in those states, compared with a national average of 85% today), found that about one in four women who were denied funding for an abortion might be likely to have one if funding were restored. More recent work using an entirely different approach yielded a similar result. Contrary to the allegations of leading antiabortion activists, however, both lead to the inescapable conclusion that although the impact on Medicaid enrollees in states that have implemented the funding restrictions may be substantial, the impact of repealing the Hyde amendment on the overall level of abortion in the United States would be minimal.

But, of course, health care reform does not repeal the Hyde amendment. In fact, it essentially has the opposite impact. By maintaining the Hyde amendment, health care reform represents the largest expansion of abortion funding restrictions since Hyde was first implemented. This is both because the health care reform law includes a dramatic expansion of the overall Medicaid program to include all individuals with incomes under 133% of the federal poverty level ($24,352 for a family of three) and because the effect of that expansion will be felt disproportionately in states that do not subsidize abortion with their own funds.

According to a 2010 study conducted for the Kaiser Commission on Medicaid and the Uninsured by researchers from the Urban Institute, the Medicaid expansion provision will bring Medicaid coverage to an additional 15.9 million Americans by 2019. More than two-thirds of these new Medicaid enrollees will live in states where Medicaid funding for abortion is currently restricted. Moreover, the impact of the expansion will be more pronounced in states in which Medicaid coverage is currently less generous and in which more residents are uninsured. As a result, the group of states in which public funds are not available for low-income women needing an abortion will see a disproportionate impact from the Medicaid expansions in health care reform: The proportion of adults who are uninsured is expected to fall by 49% in the non-funding states, compared with 41% in the states where public funds are available.

Private Insurance Coverage

Claims by antiabortion leaders about the impact of Medicaid coverage on the nationwide abortion incidence constitute a serious misuse of Guttmacher data, but any use of those data to make allegations about the impact of coverage in the private market is completely unfounded. The Guttmacher Institute has not studied the impact of private insurance coverage of abortion. In fact, any discussion of the impact of the federal health care reform law on levels of abortion among those with private coverage is speculative at this point.

What is known is that under the legislation, some 16 million individuals who would otherwise be uninsured are projected to have private coverage by 2019, according to the Congressional Budget Office. The legislation signed into law in March will make it extremely difficult for insurers to include abortion coverage in the plans they will be marketing on the health insurance exchanges through which these individuals will be purchasing insurance. Indeed, the statute's coverage restrictions are so stringent that leading insurance experts have suggested that most insurers will simply decline to sell policies covering abortion on the exchanges—and eventually in the broader private market as well. Yet, even if some newly insured women do receive coverage for abortion, there is little reason to think that it would open new doors for those women to obtain abortions that they cannot afford today. These women, by definition, will have incomes higher than those on Medicaid, as the insurance exchanges will be designed for Americans with incomes above the 133% of poverty cutoff for Medicaid. And even when income eligibility ceilings for Medicaid were much lower than they are today, and far lower than they will be in 2019, three in four Medicaid enrollees were still able to obtain an abortion in the absence of coverage.

Meanwhile, a study published in the March 2010 issue of the *New England Journal of Medicine* did look at changes in the incidence of abortion in a state that adopted a universal insurance coverage policy but without any of the kinds of abortion coverage restrictions included in the federal legislation. This analysis, by Patrick Whelan of Harvard Medical School and Massachusetts General Hospital, examined the impact of insurance coverage in Massachusetts, a state whose experiment in health care reform is often cited as the model for the federal legislation. Massachusetts enacted its own universal health care plan in 2006. Since the beginning of 2007, the state has provided subsidized coverage to individuals with an income up to 300% of the federal poverty line who are either self-employed or unemployed, as well as to small businesses. In stark contrast to the federal law, abortion is covered for individuals with subsidized coverage, known as Commonwealth Care, as well as for Medicaid enrollees.

Yet, since the enactment of health care reform, the number of abortions in the state fell from 24,245 in 2006 to 23,883 in 2008, a decline of 1.5%, even as the insured population grew by 5.9% over the same period. (The number of abortions to teens fell by 7.4% over the same time period.) According to Whelan, these decreases came during a period of rising birthrates and population growth, which meant that the abortion rate in the state declined from 3.8 per 1,000 Massachusetts residents in 2006 to 3.6 per 1,000 in 2008.

The number of abortions in Massachusetts has reached its lowest level since the 1970s, even though more residents than ever were covered by health insurance and virtually all insurance plans covered abortion. As a result, Whelan noted, "The recent experience in Massachusetts suggests that universal health care coverage has been associated with a decrease in the number of abortions performed, despite public and private funding of abortion that is substantially more liberal than the provisions of the federal legislation."

Underlying Causes and Real Solutions

History, common sense and available data all suggest that insurance coverage for abortion is not a significant driver of the incidence of abortion, any more than insurance coverage of pregnancy-related care drives the number of babies born each year. Even the legalization of abortion nationwide that came with *Roe v. Wade* in 1973 did not somehow "create" abortion. Indeed, although the U.S. abortion rate rose rapidly in the years immediately following the Supreme Court decision before leveling off in the early 1980s, this was to a considerable extent because of legal abortions replacing abortions that previously had been performed illegally and had gone uncounted.

This reality is entirely consistent with the experience in other countries with generous abortion coverage under their national health systems. In the Netherlands and Germany, for example, where almost all abortions are free to citizens, abortion rates are less than half that in the United States. And in Canada, which has no national restrictions on abortion as well as a comprehensive national health system, the abortion rate is considerably below ours.

A wealth of evidence from around the world confirms that underlying levels of unintended pregnancy are the best predictor of abortion rates. Countries with low rates of unintended pregnancy have low rates of abortion, and vice versa. But what insurance coverage can affect to a much more significant degree are the conditions under which the procedures take place. Research on poor women affected by the funding restrictions under Medicaid shows both the financial obstacles women living at or near the poverty line must surmount and the personal indignities they must endure to obtain an abortion in the absence of Medicaid coverage. Moreover, poor women having an abortion do so more than a week later than do more affluent women, likely reflecting their increased difficulty in securing funds.

Better-off women with private insurance may not have to make the same financial sacrifices that poor women do to obtain an abortion, but they face many of the same indignities. From bogus "informed consent" procedures and waiting periods to unnecessary and costly ultrasound mandates, women seeking an abortion and the professionals providing the service are subjected to a host of restrictions and requirements not imposed on any other legal medical procedure in the United States. In that light, the campaign to end insurance coverage is yet another component of a long-standing and concerted effort by abortion rights opponents to paint abortion and ensure its societal treatment as something other than a legitimate medical procedure. And that is why, however limited the relationship between abortion coverage and actual abortion incidence may be, the eventual success or failure of that campaign will be consequential. www.guttmacher.org