

## **Reproductive Health Care: The Role of Medicaid**

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Unintended pregnancy is a critical public health problem in America, leading to adverse health, economic, and educational consequences for society, as well as, the parents and infants involved. Estimates claim that almost half of the pregnancies in the United States are unintended. The number is even higher for low-income and indigent women. Cross-national comparisons find that increased sexual and reproductive behavior correlates with low levels of socioeconomic status more so in the United States than in other countries. Furthermore, the proportion of the population that is poor is at least two thirds larger in the United States than in Canada, France, Great Britain or Sweden. The high rate of poverty often is cited as the reason rates of unwanted pregnancies are higher in the United States than comparable countries. Unwanted pregnancies, in turn, contribute to the high rate of poverty found in the United States. Poverty and unwanted pregnancy are mutually reinforcing.<sup>1</sup>

Indigent women do not experience the same opportunity structure as middle-class women. These women often do not have access to quality care and frequently do not have access to specialists. Availability of care is at the core of reproductive health care for impoverished women. Without this access, the mutually reinforcing element of poverty and unwanted pregnancy causes a generational problem. Studies observe

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<sup>1</sup> “Building Knowledge, Securing Opportunities.” *The Alan Guttmacher Institute 2001 Annual Report*, Pg 25.

“poverty results in both personal and structural deprivations for women *and their children.*”<sup>2</sup>

Medicaid, the health insurance program for low-income Americans administered mutually by the states and the Federal government, is a major provider of reproductive health coverage. Though it covers six million low-income women between the ages of 15 and 44,<sup>3</sup> more than 16 million U.S. women are in need of subsidized contraceptive services and supplies.<sup>4</sup> Family planning services are essential for these women, both for their health and their children’s. These services are also essential for indigent women’s ability to join and remain in the workforce. Yet, many women remain uncovered due to state Medicaid policy technicalities, such as Virginia not covering oral contraception while New York does. Medicaid’s support for family planning services is critical for women who lack the means to pay for these services and supplies. To put bluntly, the unequal distribution of income and services and the feminization of poverty affect women’s health care.

I observed many instances where low-income women had unwanted pregnancies during my internship at Rockbridge County Community Services (RCCS) as a caseworker. The majority of these women were working, single women who received in-kind assistance, such as food stamps, and received or qualified for Medicaid. The problem that many of these women encountered pertained to family planning services. They could not afford exams or contraception. If they chose to

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<sup>2</sup> Palley, Marian Lief and Howard Palley. “Rethinking a women’s health care agenda.” *Women and Politics* Vol. 21 No. 3 2000. Pg 90.

<sup>3</sup> The Henry J. Kaiser Family Foundation. *Medicaid Coverage of Family Planning Services: Results of National Survey* October 31, 2001. Pg 7.

<sup>4</sup> *Alan Guttmacher Institute Annual Report*, Pg. 10.

spend what little income they had on these services, other necessities such as food, shelter, and utilities would be neglected—causing them to apply for assistance. One young woman in particular remains fixed in my mind. I will call her Mary Lou. Mary Lou, a pregnant, single mother of a three-year-old, worked at the Hampton Inn in custodial services. She received food stamps and Medicaid. Her income was just over the limit to receive cash assistance, TANF (Temporary Aid to Needy Families). She was devastated to realize that she was pregnant again. She knew all too well the expense of having regular pregnancy check-ups. And, too, time off from work would be detrimental to her income.

After she left her last appointment, I talked with her caseworker. There I learned that Mary Lou had wanted a prescription for an oral contraceptive, but realized the Virginia Medicaid policy does not cover oral contraception, nor could she afford the out-of-pocket expense. So where does that leave Mary Lou? More than likely, she will have to cut down on her living expenses and may have to find cheaper rent in order to afford her unwanted pregnancy. This could have been prevented if only her health insurance, Medicaid, had covered all reproductive health care.

Through my research, I found that Medicaid's coverage throughout time has expanded and contracted, placing different emphasis on different aspects of reproductive health care. However, reproductive health care ethics demonstrate that there truly is no gray area. In order for women to have basic freedoms and rights, their reproductive health care has to be accessible regardless of their socioeconomic class. The solution is for Medicaid to standardize its reproductive health care coverage and accessibility across state lines.

## **MEDICAID: THEN & NOW**

### **Medicaid to Medicaid Managed Plans**

The Federal Medicaid program has long emphasized family planning. In 1972, the Title XIX statute was amended to require that state Medicaid programs cover family planning services and supplies for eligible beneficiaries.<sup>5</sup> Despite Medicaid program's emphasis on family planning services, the Health Care Financing Administration (HCFA) has never formally defined "family planning."<sup>6</sup> The State Medicaid Manual explains that the Medicaid statute and regulations do not define this service; therefore, no specific guidelines or regulations exist to determine which family planning services must be provided under state Medicaid programs. Yet, the importance of these family planning services was reinforced by the establishment of a Federal matching rate (or "FFP," for Federal Financial Participation) of 90 percent, rather than the usual 50 to 80 percent, for family planning services.<sup>7</sup>

Although specific guidance is not provided, the Medicaid State Operations Manual provides a general list of the types of services that are eligible for FFP:

In general, FFP at the 90 percent matching rate is available for the costs of counseling services and patient education, examination and treatment by medical professionals in accordance with applicable State requirements, laboratory examinations and tests, medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception, and infertility services, including sterilization reversals. (Health Care Financing Administration-HCFA, 1988).

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<sup>5</sup> KFF. *Medicaid Coverage*. Pg 7.

<sup>6</sup> *Ibid.* Pg 13.

<sup>7</sup> *Ibid.* Pg 7, 13

In 1993, HCFA clarified the circumstances in which specific services could be claimed as family planning services.<sup>8</sup> First, services intended to prevent or delay pregnancy, including laboratory tests, counseling, medical procedures, sterilization and infertility treatment, and pharmaceutical supplies and devices are considered to be family planning services.<sup>9</sup> Mary Lou's story is evidence that these services are the most important point of family planning. They allow women to make informed decisions concerning pregnancy. However, pregnancy testing may be considered to be family planning *only if* it is conducted as part of an initial or annual family planning examination or if it is conducted in a family planning clinic.<sup>10</sup> This condition is irrational and has no formal explanation. Mary Lou's story further illustrates the absurdity of this qualification. She had her pregnancy test taken at Stonewall Jackson hospital. Because the test was not done at a clinic, the cost was an added expense to her already limited budget. As you may guess, this qualification often hinders women from having official tests conducted and (or) can prevent women from taking adequate care of themselves and the child in early stages.

Because Medicaid only covers procedures that are considered family planning—the delay or prevention of pregnancy—procedures performed for medical reasons are not considered to be family planning, and are therefore, not covered. Also, abortions are not considered family planning services.<sup>11</sup> Although I agree that abortions should not be “planned,” the procedure should be funded if a woman

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<sup>8</sup> Ibid.

<sup>9</sup> Ibid. Pg. 18.

<sup>10</sup> Ibid. Pg. 18-19.

<sup>11</sup> Ibid. Pg. 20.

chooses to have one—this choice should not be based on affordability. Abortion will be covered in more depth in the ethics portion of this paper. Services conducted as part of an inpatient hospital stay, such as a tubal ligation, may be considered to be family planning, but the entire hospital charge would not be eligible for the 90 percent match. States must develop a methodology for allocating the appropriate portion of the cost of a hospital stay to the family planning services.<sup>12</sup> Although inpatient hospital stay is a significant cost factor in family planning, it will not be covered in this paper.

Multiple levels of outreach and education are needed to assure women access to the family planning services covered under Medicaid. Changes in policy at both the state and Federal levels are shifting the way family planning services are delivered and financed under Medicaid. In 1999, 56 percent of Medicaid enrollees were served through managed care organizations compared to 14 percent in 1993.<sup>13</sup> This proportion is likely to be much higher for women of reproductive age, since categories through which they qualify for Medicaid are those most frequently required to enroll in managed care plans. For example, many managed care plans require that the individual enrolled have dependents. These plans control program costs and improve access to services. Once enrolled in Medicaid, enrollees need to know about their options for using family planning services. In states that have “open access” or “freedom of choice,” the enrollee must be informed that they can use any Medicaid certified family planning provider, including those outside the plan’s network.<sup>14</sup> The use of managed care to deliver services

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<sup>12</sup> Ibid. Pg. 22.

<sup>13</sup> Ibid. Pg 13.

<sup>14</sup> Ibid. Pg. 35

to Medicaid enrollees has the potential to increase their access to private-sector primary care providers and gynecologists, but may also make it more difficult for women to use the traditional sources of family planning services, such as free-standing family planning clinics and community health centers, which they have traditionally relied.<sup>15</sup> Medicaid managed plans have been financially detrimental for women like Mary Lou. Stonewall Jackson Hospital does not provide a managed care plan that covers reproductive health. And furthermore, Mary Lou's access to family planning services is limited—the nearest facility is fifty miles away in Roanoke.

### **The Crisis of Enrollment: PRWORA**

In addition, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) has complicated women's access to Medicaid coverage.<sup>16</sup> Welfare reform severed the connection between Medicaid eligibility and receipt of cash assistance and imposed limits on the length of time families could receive cash benefits. As a result, a number of women (and their children) have “lost” or will lose their Medicaid benefits. Ironically, they may not have lost their eligibility.<sup>17</sup>

Although Medicaid eligibility is not subject to these time limits and its eligibility standards have not changed, confusion on this point is common, and analysts have noted significant declines in Medicaid enrollment since the implementation of welfare reform; particularly notable was the decline of women of

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<sup>15</sup> Miller, Virginia. “Contraceptive Decision Making Among Medicaid-Eligible Women.” *Journal of Community Health*. Vol. 25 No. 6. December 2000. Pg. 473.

<sup>16</sup> KKF, *Medicaid Coverage*, Pg. 10.

<sup>17</sup> Palley. “Rethinking a Women's Health Care Agenda.” Pg. 90.

reproductive ages and their children.<sup>18</sup> Between 1994 and 1998, the proportion of women of reproductive age enrolled in Medicaid fell from 12.6 percent to 9.9 percent, a decline of 21 percent.<sup>19</sup> Also, these changes in Medicaid policy and programs are beginning to be reflected in the programs total expenditures for family planning and the number of beneficiaries receiving those services. In FY 1998, the Medicaid program reported providing family planning services to just over 2 million recipients for a total expenditure of \$449 million.<sup>20</sup> This represents a decline since FY1994, when it was reported 2.6 million users of family planning services and an expenditure of more than \$500 million. Over this period, total Medicaid expenditures rose from 108.3 billion in 1994 to \$142.3 billion in 1998, while the amount spent on family planning remained stable or declined.<sup>21</sup> These figures do not include users and expenditures under managed care programs since the data are not easily collected, nor separated out for reporting purposes. As these programs have grown, it has become more difficult to determine the number of Medicaid recipients who are using family planning services and the amount the states and the Federal government spend on these services.<sup>22</sup>

Additionally, women who lose their Medicaid coverage as the result of moving from welfare to work often are employed in low-wage jobs with no employer-sponsored health care benefits. For Mary Lou, this is not a problem. She qualifies for Medicaid throughout her pregnancy and into the first years of her child's life. But after this time

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<sup>18</sup> Ibid.

<sup>19</sup> KKF, *Medicaid Coverage*, Pg. 10.

<sup>20</sup> Ibid. Pg. 11.

<sup>21</sup> Ibid.

<sup>22</sup> Ibid. Pg. 11-12.



pasts, she would have no health care insurance, for she no longer would qualify for Medicaid (although her children qualify under the 1996 SCHIP program). Overall, the increasing number of women losing their Medicaid coverage places a particularly tight squeeze on other public funding such as Title X.<sup>23</sup>

## **INADEQUATE FUNDING: The Story of Title X**

In addition to Medicaid, there are other Federal sources of funding available to help low-income women obtain reproductive health services, primarily through Title X Family Planning Program, which is the focus of this section. Other funding services include Title V Maternal and Child Health Block Grant, The Title XX Social Services Block grant, or state funds. These programs often supplement Medicaid for ineligible women or are used to cover services that Medicaid does not. Title V has, since 1968, required states to spend 6 percent of Federal allocations on family planning services.<sup>24</sup> Title XX is allocated to state social service agencies, which have broad discretion over the use of the funds. States design their own programs that are aimed at preventing, eliminating, or reducing dependence on government aid and promoting self-sufficiency. Family planning is the only medical service specified in the statute. Although states are not required to fund family planning services, Title XX has traditionally been an important source of family planning services in some states.<sup>25</sup> The problem with these

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<sup>23</sup> Dailard, Cynthia. "Challenges Facing Family Planning Clinics and Title X." *The Guttmacher Report On Public Policy*. Volume 4, Number 2, April 2001. Pg. 5.

<sup>24</sup> Ibid.

<sup>25</sup> Ibid. Pg. 31

programs is that they place the power of the “purse strings” with the state, unlike Title X, which is federally mandated.

Established in 1970 by Congress as Title X of the Public Health Service Act, the National Family Planning Program provides funding for comprehensive family planning services through a categorical grant program. In 1970, Congress enacted Title X, the only *federal* program—then and now—devoted solely to the nationwide provision of family planning facilities. Introduced with bipartisan support and signed into law by President Nixon, Title X was designed to make contraceptive supplies and services available to all who want and need them but are unable to afford them without government assistance. The new program sought to fulfill Nixon’s historic 1969 promise that “no American woman should be denied access to family planning assistance because of her economic condition.”<sup>26</sup>

The Title X program funds a network of 4,600 family planning clinics, which provided services to an estimated 5 million low-income women in 1999.<sup>27</sup> It is important that these clinics be financially supported because they provide the services to low-income women that are covered under Medicaid. This aspect is what makes Title X so important compared to Title V and Title XX.

In addition to providing high-quality, affordable family planning services (via clinics) to low-income women, Title X also established a set of principles that guide the ethical delivery of those services.<sup>28</sup> Those principles require that services be voluntary, confidential, and affordable. Accordingly, women must be offered a broad

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<sup>26</sup> Ibid. Pg. 1.

<sup>27</sup> KFF, *Medicaid Coverage*, Pg. 30.

<sup>28</sup> Dailard, *Guttmacher Report*, Pg. 3.

range of contraceptive methods (including natural planning) and may not be pressured to accept a particular method or any method at all; confidentiality must be guaranteed. Services must be offered free of charge to clients with incomes below the federal poverty level (Medicaid recipients) and on a sliding scale for clients with incomes between 100% and 250% of poverty.<sup>29</sup> Services include pelvic and breast examinations, blood pressure checks, pregnancy tests, Pap smears and, as indicated, tests for sexually transmitted diseases (STDs).<sup>30</sup> As mentioned earlier, Mary Lou had to pay out-of-pocket for her pregnancy test because she did not go to a family planning clinic sponsored by Title X. But this was due to the nearest family planning clinic being located in Roanoke and she was without transportation.

The Title X statute specifies that program funds cannot be used for abortion, but that a pregnant woman must be offered “nondirective counseling” about all of her options, “including prenatal care and delivery; infant care, foster care or adoption; and pregnancy termination.”<sup>31</sup> Title X has been enormously successful in helping American women plan their births and avoid one million unintended pregnancies each year, thus improving the public health.<sup>32</sup>

Thirty years after its enactment, the Title X program remains the centerpiece of the U.S. family planning effort. Its support of clinic infrastructure and clinics’ operating budgets, enables them to draw on other sources of revenue for family planning. In other words, it frees up Medicaid funds for direct family planning

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<sup>29</sup> Ibid. Pg. 4.

<sup>30</sup> Ibid.

<sup>31</sup> Ibid.

<sup>32</sup> Ibid. Pg. 3.

services.<sup>33</sup> Together, Medicaid and Title X funds support more than 7,000 family planning clinics nationwide, more than 4,500 of which receive Title X funds. Of the 6.5 million women who receive subsidized family planning services each year, two-thirds do so at a Title X-supported clinic.<sup>34</sup>

Although the importance of Title X and all that it has accomplished is significant, funding for it has decreased 60% in real dollars since 1980.<sup>35</sup> Funding for the program grew rapidly in the 1970s, as clinics proliferated throughout the country; however, in 1981, shortly after taking office, President Reagan tried to repeal Title X entirely and to send federal family planning funds—and policymaking authority—to the states.<sup>36</sup> The 1980s saw further controversy emerge when social and religious conservatives began alleging that the very availability of family planning services promoted promiscuity and abortion. These controversies, which remain alive today, helped keep funding low throughout the decade. During the 1990s, appropriation began to rise again, but the program never regained the ground it lost during the previous decade. In fact, taking inflation into account, the \$254 million in FY 2000 funding is 58% *lower* than the \$612 million appropriated in 1980, the final year of the Carter administration. If spending had kept pace with inflation, the program would be funded at \$564 million today.<sup>37</sup>

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<sup>33</sup> Ibid

<sup>34</sup> Ibid. Pg. 1.

<sup>35</sup>“Building Knowledge, Securing Opportunities.” *The Alan Guttmacher Institute 2001 Annual Report*, Pg. 10.

<sup>36</sup> Ibid.

<sup>37</sup> Dailard, *GuttmacherReport*, Pg. 8.

## THE PROBLEM: State Variations

Many states have established six categories of family planning services: exams and counseling services, prescription contraception, over-the-counter contraception, sterilization, screening and treatment, and conception and infertility. This paper focuses on prescription contraception, over-the-counter contraception, and exams and counseling services. Nearly all states cover both medical procedures and supplies involved in providing all currently approved prescription methods of contraception, including oral contraceptives, intrauterine devices, contraceptive implants and injections, and diaphragms. A few states, however, are not consistent in their coverage. Louisiana covers all medical procedures, but not all of the supplies, and South Dakota and North Carolina cover all methods but diaphragms. In the case of Mary Lou, we see that Virginia does not cover all forms of oral contraceptives. This method of birth control was not an option for her under Medicaid. There is no formal reason for this discrepancy. Finally, coverage for emergency contraception, or methods of preventing pregnancy after unprotected intercourse, is less universal; only 27 states and DC reported covering this service.<sup>38</sup>

Medicaid covering oral contraception is very important. Unlike the social and religious conservatives of the 1980s (and those of today), the government's role is not to regulate women's sexual behavior. Oral contraception provides the first line of defense in preventing unwanted pregnancies, and the woman without consideration of budget constraints should decide these pregnancies.

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<sup>38</sup> *Ibid.*

Over-the-counter contraception is also very important in preventing unwanted pregnancies. Thirty-two states and DC reported covering certain over-the-counter methods and supplies, consisting of condoms, spermicide, and sponges. In addition, Alaska, New York, Texas, and Wisconsin reported covering female condoms. Five states, including Maine, Missouri, North Carolina, Tennessee, and Utah cover no over-the-counter methods, and Delaware and Vermont cover spermicide but not condoms.<sup>39</sup>

Many states do not cover contraceptive counseling and reproductive health education. Eleven states do not cover contraceptive counseling as a distinct service and 17 do not cover reproductive health education. For example, only 18 states consistently classify gynecological exams as family planning, while 27 will do so if provided during a family planning visit.<sup>40</sup> By not covering the expense of counseling and reproductive education, the state is preventing women from making informed decisions early in the process, and may result in the difficult decision of abortion later on.

Under state Medicaid programs many states may not be taking full advantage of the opportunity to receive the enhanced Federal matching rate for family planning services, as many states do not cover all of the “preventive” services that may be classified as family planning. Although the categories of screening, and infertility are important aspects of family planning, they do not fit into the realm of preventing

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<sup>39</sup> Ibid., 22-26.

<sup>40</sup> Ibid.

unwanted pregnancies for the low-income and indigent women, which is the focus of this paper.

## **A WOMAN'S RIGHT: WHY COVER REPRODUCTIVE HEALTH CARE**

The idea of reproductive health care rights and reproductive freedom cannot be considered apart from the exercise of other basic human rights. Reproductive freedom lies at the core of individual self-determination, while reproductive health care rights provide an essential foundation for opportunity and progress. They are therefore, central to the security of individuals and societies.<sup>41</sup> At least three types of reproductive rights can be distinguished: (1) the freedom to decide how many children to have and when to have them; (2) the right to have the information and means to regulate one's fertility; (3) the right to "control one's own body." The second right has been formalized in various U.N. declarations since the mid-1960s while the third has emerged primarily from feminist discourse.<sup>42</sup>

Philosophically, reproductive health care is a "negative right," a right which the government and other members of society cannot prohibit one from enjoying. The United States does not prohibit this negative right. However, I argue that it prohibits the "positive right" of reproductive health care, that is the ability to "access" the goods and services of reproductive health care. The protection of "negative rights" requires positive measures (i.e. access through Medicaid coverage), and therefore their actual enjoyment

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<sup>41</sup> Dixon-Mueller, Ruth. *Population Policy & Women's Rights: Transforming Reproductive Choice*. (Westport, Connecticut: Praeger, 1993) Pg. 12.

<sup>42</sup> Ibid.

requires positive measures.<sup>43</sup> For poor women, the denial of positive rights is nearly tantamount to denying the negative right.<sup>44</sup> In this the discussion, the first right stated above is a negative right but has no worth without the second and third rights, which are positive.

### **The “Know & How”**

Every woman should possess the reproductive right and freedom to be able to regulate her fertility, that is, the right to obtain and have access to family planning information and services. From its tentative origins in U.N. documents as a right “to adequate education and information” permitting women to regulate their fertility, the concept was broadened to include the right to the “information, education and means to do so.”<sup>45</sup> This right must be an entitlement. If women are to exercise their reproductive freedom, they are entitled to have the means to do so safely and effectively. In practical terms, what does this right mean? Women should have a right to family planning, which presumably involves a right to use and have access to contraceptive methods, along with the right to learn about, obtain, and use modern methods. Therefore, governments should not intervene to prevent women from obtaining or using a contraceptive method. By doing so, they are interfering with women’s positive rights!

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<sup>43</sup> Shue, Henry. *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy*. Second Edition. Princeton University Press, New Jersey 1980. Pg. 39.

<sup>44</sup> Beckley, Harlan. *Comments: Draft 4*. April 3, 2003.

<sup>45</sup> *Ibid.* Pg. 13.



However, this is exactly what the United States does. The health care available to indigent women is to a considerable degree dependent on the financial resources and public health expenditure of national governments, more specifically the budgetary allocations for women's health. While women in some states and localities lack even basic facilities, women in other states may have access to every advanced medical service. In the states where Medicaid is poorly funded, basic reproductive health care services are grossly insufficient.<sup>46</sup> In states where for economic and logistic reasons health care services are poorly staffed and equipped, the implementation of good quality reproductive health care for women is faced with more difficulties than in more progressive states.<sup>47</sup>

It has become more and more apparent that access to reproductive health care has a disparate impact. In the early 1980s, poor women in the United States were less likely to use contraceptives than higher-income women, and black and Hispanic women were less likely to do so than white women. Yet research has shown that women of all income levels wanted about the same number of children.<sup>48</sup> With the availability of free or low-cost contraceptive services at publicly funded family planning clinics, contraceptive use among poor, low-income and minority women gradually increased so that by the end of 1999, it matched that of higher-income and

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<sup>46</sup> Kolk, Annemaria M. "Gender Perspectives and Quality of Care: Towards Appropriate and Adequate Health Care for Women." *Social Science and Medicine*. Vol. 43. Issue 5. 1996 pg. 709.

<sup>47</sup> Ibid.

<sup>48</sup> Ibid. Pg. 15.

white women.<sup>49</sup> Helping all U.S. women plan to have children when and if they choose to.

### **The Deciding Factor**

The right to “control one’s own body” is a much more comprehensive reproductive right and freedom. The right to control one’s body—that is, to determine what one does with it and has access to it—can apply to a woman’s right *not to be alienated from her sexual and reproductive capacity* (e.g. prevention of access to contraception or abortion) and to her right to the *integrity of her physical person* (e.g. freedom from unwanted pregnancies).<sup>50</sup> This concept of reproductive rights feeds directly into a woman’s right to choose abortion without any financial hindrance. It also relates to the idea of “positive” and “negative” rights discussed earlier.

Abortion is a particularly polarizing issue, often presented as a stark dichotomy between a woman’s freedom of choice and a fetus’s right to live. Often lost in the debate are the real lives and difficult decisions of women who obtain abortions. Evidence from around the world reveals little correlation between legality

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<sup>49</sup> Alan Guttmacher Institute Annual Report, Pg. 15.

<sup>50</sup> Ibid. Pg. 14.

of abortions and abortion incidences; however, there is a high level of abortion incidences when there is a high levels of unwanted pregnancy.<sup>51</sup> During a symposium on Women's Rights, this was said:

The right to safe, legal abortion is the *sine qua non* of a woman's ability to control her personal destiny. Without it, women cannot gain access to or participate effectively in the political and social process which shape every aspect of their lives. The degree of control women are able to exercise over their reproductive lives directly affects their educational and job opportunities, income level, physical and emotional well being, as well as the economic and social conditions the children they do bear will experience.<sup>52</sup>

Medicaid coverage for abortion has long been a source of controversy on both state and local levels. Henry Hyde first introduced the Hyde Amendment to Congress in 1977. This legislation denies women on Medicaid the right to coverage of abortion services by Medicaid. The only exceptions to this rule are in cases in which the woman's life is endangered by a continuation of the pregnancy or the woman's pregnancy is the result of rape or incest.<sup>53</sup> States may voluntarily use state funding to cover abortion services in their state Medicaid health coverage beyond the provisions of life endangerment, rape or incest. However, only 15 states do so.<sup>54</sup>

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<sup>51</sup> Ibid. Pg. 26.

<sup>52</sup> Taub, Nadine. "A Symposium of Reproductive Rights: The Emerging Issues." *Women's Right sLaw Reporter* Vol. 7, No. 3 Spring 1982. Pg 169.

<sup>53</sup> "The Hyde Amendment." *Campaign for Access and Reproductive Equity 2000*. Pg. 1

<sup>54</sup> Ibid.

Low-income women, women of color, and young women on Medicaid are directly affected by this legislation. State restrictions on public funding for abortion make it extremely difficult and, often, impossible for Medicaid recipients to exercise their constitutional right to safe and legal abortion.<sup>55</sup> Because of their “second class” citizenship in the United States, it appears that these women do not have the same rights as other American women who can finance an abortion out-of-pocket or through private insurance coverage. These women are the first to be disregarded in the fight for control over women’s reproductive freedom.<sup>56</sup>

Women on public assistance often face a double bind: no help in paying for abortion services in cases of unwanted pregnancies and no financial support after childbirth because of punitive welfare reform legislation like TANF that allows states discretion in imposing family caps.<sup>57</sup> The federal and state bans on public funding for abortion subject women to dire hardships. A 1984 study showed that 44 percent of women on Medicaid who obtained abortions that year paid for them with money earmarked for living expenses, such as food, rent, and utilities.<sup>58</sup> The delays that ensue as women try to scrape together funds cause many women to have later, riskier, and more costly abortions. Some women are forced to carry unwanted pregnancies to term. Studies have shown that from 18 to 33 percent of Medicaid-eligible women who want abortions, but who live in states that do not provide funding, have been

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<sup>55</sup> “Access Denied: Origins of the Hyde Amendment and Other Restrictions on Public Funding for Abortion.” *American Civil Liberties Union*. Pg 1.

<sup>56</sup> *Ibid.* Pg. 3.

<sup>57</sup> *Campaign for Access*, Pg. 4.

<sup>58</sup> *American Civil Liberties Union*, Pg. 6.

compelled to give birth.<sup>59</sup> The Hyde Amendment is just another policy among others that denies women full reproductive choice options by setting restrictions on services covered by Medicaid.

All of the elements of reproductive health care rights and freedoms mentioned here incorporate principles of individual liberty, not the moral aspect of abortion. I only argue that as long as abortions are legal, a woman's income should not be the deciding factor in having one. A woman should have the freedom not to suffer the harmful consequences of unwanted pregnancy.

## **Access & Knowledge: EMPOWERMENT**

I understand that there are times when the evidence points unmistakably to a particular set of policy and program interventions, but these policies and programs are not put into place. Sometimes this is because the information has not reached the people who can use it most effectively. At other times, it is because ideological or political pressures inhibit stakeholders from supporting the necessary changes.<sup>60</sup> However, the solutions I would recommend seem nothing more than common sense: first, to standardize Medicaid coverage categories and to standardize coverage across state lines and secondly, to increase accessibility of all reproductive health care regardless of socioeconomic status. The United States already has a significant start. Publicly supported family planning services help U.S. women avoid 1.3 million unintended pregnancies each year; without this support, the birthrate of indigent women would be

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<sup>59</sup> Ibid.

<sup>60</sup> Alan Guttmacher Institute Annual Report, Pg. 28.

25 percent higher than it is.<sup>61</sup> Policymakers must build on this effort.

Standardization of Medicaid coverage and services is the most important issue to tackle. If Mary Lou had been a resident of New York when asking for oral contraception, the cost would have been covered under Medicaid. This is an inequality that should not be suffered. Federal policy makers need to come together and formally standardize all reproductive health care categories so that no variance exists across states. Once categories are standardized, each state must find funds to provide the minimal coverage in all categories. This may include Federal block grants to states, raising state taxes, an increase in Title X funding and so forth. The point is, inequality among groups who are disadvantaged on account of their geography or income, or by virtue of gender, race, or ethnicity should not be tolerated. This point would be most demonstrated in a repeal of the Hyde Amendment. Policymakers have the opportunity to address the gaps that remain and to secure a better and more hopeful future for all involved.

Once standardization occurs, access to safe and effective methods of fertility regulation will empower women. The knowledge of how to avoid pregnancy gives women the means to shape their lives in ways undreamed of by those who have never questioned the inevitability of frequent childbearing or who have resorted in desperation to cumbersome, ineffective, and often dangerous methods to stop unwanted births. Being able to plan whether and when to have a child helps women and men around the country educate and nurture their children, enabling those children to establish themselves in a

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<sup>61</sup> Alan Guttmacher Institute Annual Report, Pg. 16.

workforce so they in turn are able to support families. Eliminating unsafe and unwanted pregnancy also contributes to healthier mothers and children.<sup>62</sup> In a broader sense, sexual and reproductive health and rights enable men and women to form healthier, more open and more equal relationships.

Access to means and access to information continues to threaten the ability of people around the country to exercise their reproductive choices and build a secure future for themselves and their families. Through standardizing Medicaid coverage these gaps will turn into opportunities, through improving access and knowledge of reproductive health care for all individuals. Securing a hopeful future for all women, and most significantly, women like Mary Lou, demands that we as a society construct and sustain an unyielding foundation of sexual and reproductive health and rights.



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<sup>62</sup> Ibid.

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