The Hyde Amendment & Asian American and Pacific Islander Women

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In 1973, in a historic victory for women, the Supreme Court held in *Roe v. Wade* that the constitutional right of personal privacy includes the decision to have an abortion. In the years immediately following the Court's decision, like other medical care, abortion was covered under the federal Medicaid program. However, in 1976, Congress passed the Hyde Amendment, a rider to the federal budget that denies coverage for abortion in federal health care programs in all but the narrowest circumstances of rape, incest, and the life of the mother. Every year since then, Hyde has been attached as an amendment to every budget bill. To this day, Hyde continues to create unjust obstacles to care for millions of women struggling to get by.

THE HIGH COST OF HYDE

The current iteration of the federal Hyde Amendment provides for a narrow set of exceptions under which a person may be covered for abortion care—namely, in the circumstances of rape, incest, and where the life of the mother is in danger due to physical disorder, illness, or injury. State Hyde restrictions often have the same or similar exceptions. However, even in the rare circumstances where a person meets these exceptions, many additional factors make it difficult for them to receive the care that they need.

On average, the cost of a first-trimester abortion is $470,[1] but can cost as high as $800 for a medication abortion,[2] and as high as $1,500 for a non-medication, in-clinic procedure.[3] After the first trimester, these costs increase exponentially—at 20 weeks of pregnancy, the average cost of an abortion rises to a staggering $1,500.[4] One study found that 57% of abortion patients bear these enormous costs without insurance and are forced to pay out of pocket.[5] In addition to paying for the procedure itself, the ultimate cost of an abortion for many people will also include costs associated with travel, childcare, and loss of income from time taken off of work. For more than half of all women, total out-of-pocket costs for an abortion are equivalent to more than one-third of monthly personal income.[6]

Many low-income women struggle to scrape together enough money for an abortion, which creates significant delays in accessing first-trimester abortions. On average, low-income women take up to three weeks longer than others to obtain an abortion because they may need time to raise money for the procedure.[7] Women who experience delays in access to abortion services are more likely to be denied abortion services altogether due to gestational limits or other restrictions. Researchers estimate that over 4,000 women each year are unable to obtain abortion services under such circumstances.[8]

Moreover, women who would choose to have an abortion but are unable to do so are three times more likely to fall into poverty than those who are able to afford abortion care.[9] Between 18–35% of Medicaid-eligible women reported that they would have had an abortion if funding had been available, but instead were forced to carry their pregnancies to term.[10]

COVERAGE IN THE STATES

At a minimum, states must cover those abortions that meet the federal exceptions under Hyde. However, states are also allowed to provide greater coverage than what is required under federal law. As a result, whether a woman is able to afford the abortion care she needs often depends on what state she lives in.

As it stands, 17 states provide coverage for all or most medically necessary abortions above and beyond what is required under federal law. Thirty-two states and the District of Columbia follow the federal standard, with some providing additional exceptions for fetal anomaly and where an abortion is necessary to prevent grave and long-lasting damage to a woman's physical health.[11]

Many states with the fastest growing Asian American and Pacific Islander (AAPI) populations are among those that limit coverage of abortion to the narrowest circumstances. This includes Nevada, where the AAPI community has grown over 116% since 2000, North Carolina, North Dakota, and Texas.[12] Another state with one of the fastest growing AAPI populations in the country, South Dakota, provides coverage only in the case of life endangerment, in violation of federal law.[13]

IMPACT ON ASIAN AMERICAN & PACIFIC ISLANDER WOMEN

One common misperception about the Asian American and Pacific Islander community is that its members are high achieving, well-educated, and well-resourced. However, nearly 13% of all AAPI women live in poverty, compared to 9.6% of their white counterparts.[14] When disaggregated by ethnicity, that number rises to as high as 35.6% of all Burmese, 28.0% of all Hmong, and 17.3% of all Nepalese women.[15] For many AAPI women already struggling to make ends meet, having to bear the high cost of paying for an abortion out-of-pocket would be devastating.

Before implementation of the Affordable Care Act (ACA), 1 in 10 Asian Americans, 1 in 7 Native Hawaiians and Pacific Islanders, and 1 in 5 Southeast Asians received health care coverage under Medicaid.[16] After the expansion of Medicaid under the ACA, nearly 80% of all uninsured AAPIs now qualify for Medicaid.[17] Most recent data reports that approximately 17.7% of AANHPI people still lack insurance.[18]

The picture is even more complicated when you factor in immigration. Of women of reproductive age, 40% of non-citizen

immigrants do not have insurance—more than double that of naturalized immigrants (18%) and U.S. born citizens (15%).[19] Additionally, nearly 10% of AAPI women immigrants are uninsured, while nearly one third of AAPI immigrant women rely on public insurance.[20] And an even higher percentage (35%) of non-citizen immigrants are uninsured. This percentage is higher for low-income, undocumented immigrant women.[21]

CALL TO ACTION

NAPAWF calls upon policymakers to remove all language in annual appropriations legislation that restricts coverage for or the provision of abortion care in public health insurance programs. Policymakers should also enact and support proactive legislation, such as the Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act, to permanently repeal these abortion coverage bans and prohibit states from interfering with abortion coverage in private insurance plans, including in state healthcare exchanges.

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