



January 10, 2014

The Honorable Jerrold Nadler, Ranking Member
Judiciary Subcommittee on the Constitution and Civil Justice
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. 7, the No Taxpayer Funding for Abortion Act, on which a hearing was held before the Subcommittee on the Constitution and Civil Justice on January 9, 2014.

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 an article directly relevant to H.R. 7: "Insurance Coverage of Abortion: Beyond the Exceptions For Life Endangerment, Rape and Incest" from the *Guttmacher Policy Review*, attached for inclusion in the record.

A primary purpose of H.R. 7 is to write into permanent law the Hyde Amendment, which has been incorporated into annual appropriations law since 1976 and 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. 7 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.

Moreover, HR 7 would extend the harms of the Hyde amendment and its progeny further by seeking, under the disingenuous "no taxpayer funding" label, to eliminate abortion coverage in the private health insurance market too. The effect of this new incursion would be to take abortion coverage away from many women for whom this has been a standard health insurance benefit for a long time.

As discussed in "[Insurance Coverage of Abortion: Beyond the Exceptions For Life Endangerment, Rape and Incest](#)," the Hyde Amendment is a pernicious law that explicitly targets the poorest and most vulnerable women. 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. Research shows that one in four Medicaid enrollees who want to terminate an unwanted pregnancy are unable to do so because they can't come up with the necessary funds. As the all-important Medicaid expansions take effect this year in 25 states and the District of Columbia, it is a perverse irony that one result is that even more women are

now subject to the Hyde amendment. Roughly 9.7 million women of reproductive-age were enrolled in Medicaid as of 2012; millions more will qualify as states opt to raise Medicaid income eligibility to 138% of the federal poverty line.

Many women who are purchasing private insurance coverage on the new health insurance exchanges may well be ensnared by Hyde-like restrictions as well. Under the Affordable Care Act, federal subsidy dollars for individuals purchasing plans on the health insurance marketplaces may not be used to pay for abortion coverage, except in cases of life endangerment, rape or incest. As of 2012, roughly 37.5 million women aged 15–44, accounting for 60% of women of reproductive age, were privately insured.

I would like to address a point on which Guttmacher research is frequently invoked and misrepresented. While one in four Medicaid enrollees who would have an abortion if it were covered under Medicaid is unable to do so, it does not follow that restoration of federal Medicaid coverage would result in a commensurate increase in the incidence of abortion nationwide. 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, the research shows that repealing the federal Hyde Amendment 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 only a 2.5% increase in the total number of abortions performed nationwide.

In conclusion, both for public and private insurance coverage of abortion, this bill ignores the reality that abortion is a legal, constitutionally protected and medically appropriate health care service. The Hyde Amendment and its progeny should be repealed, not reinforced, and certainly not expanded further into the private insurance market.

Thank you for the opportunity to provide these comments.

Sincerely,

A handwritten signature in cursive script that reads "Susan A. Cohen".

Susan Cohen
Acting Vice President for Public Policy

Insurance Coverage of Abortion: Beyond the Exceptions For Life Endangerment, Rape and Incest

By Heather D. Boonstra

In recent years, antiabortion activists have made significant political and legislative gains at the federal and state levels. In at least one way, however, they may be overplaying their hand, by pressing for nearly absolute bans on abortion, even in instances of rape. In June, controversy erupted during debate on a bill to ban nearly all abortions late in pregnancy. The bill's author, Judiciary Subcommittee on the Constitution Chairman Trent Franks (R-AZ), defended the lack of a rape exception in the original bill by asserting that "the incidences of rape resulting in pregnancy are very low."¹ Within hours of Franks' comments, the Internet lit up with comparisons to Todd Akin and Richard Mourdock. In August 2012, leading up to the fall elections, Akin—the Republican Senate nominee from Missouri—provoked ire across the political spectrum when he suggested that exceptions for abortion in cases of rape were unnecessary because in the case of a "legitimate rape," a woman's body could "shut the whole thing down."² Two months later, Mourdock—the Republican Senate candidate from Indiana—drew national opposition for having said in a debate that he believed pregnancies resulting from rape were a "gift from God" and should not be terminated.³ These remarks and their aftermath damaged the Republican Party on the national stage, which likely helped Democrats win several seats and keep control of the Senate.

For abortion rights advocates, these incendiary comments provided an opening. In December 2012, advocates were able to mobilize support for a small but significant change in the Defense Department authorization bill for 2013. The change broadened coverage for abortion services

for servicewomen and military dependents to include cases of rape or incest—beyond only when the woman's life would be threatened by continuing her pregnancy. This breakthrough brought federal abortion policy for U.S. servicewomen into line with the Hyde amendment, which provides for the use of federal funds for abortion under Medicaid only in these three circumstances. It also has provided momentum for softening the antiabortion law that affects Peace Corps volunteers and for revisiting the interpretation of the decades-old antiabortion law governing aid to developing countries (see related article, page 9).

These developments represent steps in the right direction, yet the pursuit of this incremental approach risks sidelining a critical but daunting task: confronting the injustice of the Hyde amendment itself. The practical impact of restrictions on abortion coverage under Medicaid are real and can be measured both in the sacrifices of women struggling to find another source of funds for an abortion, and in the unplanned and often unwanted births to those unable to do so. Achieving true equity in access to abortion coverage for low-income women goes to the heart of what it means to possess a right to safe and legal abortion that is not merely theoretical, but also meaningful.

In the Beginning

Overturning *Roe v. Wade*—and going further to make abortion illegal nationwide—has been the antiabortion movement's ultimate goal for four decades. In the years immediately following the 1973 Supreme Court decision, the primary focus of antiabortion activists' public and legislative agenda was on an ultimately futile effort to pass a

“human life amendment” to the U.S. Constitution that would establish personhood “from the moment of fertilization.” At the same time, antiabortion activists threw their support behind efforts to limit access to abortion care. In 1973, Congress passed the Helms amendment, which banned the use of U.S. foreign assistance to pay for the “performance of abortion as a method of family planning.” The passage of the Helms amendment laid the groundwork for a similar domestic measure championed by the late Rep. Henry Hyde (R-IL) a few years later.

The first version of the Hyde amendment, passed in 1976, banned the use of federal funds for abortion services, except in cases where the life of the woman was at stake, for all programs administered by the Department of Health, Education and Welfare (now the Department of Health and Human Services). The measure had the effect of banning abortion coverage for women insured by the Medicaid program.

During debate over the measure, Hyde himself acknowledged the blatantly discriminatory nature of the proposal. He argued that abortion should be included in the category of luxuries available to wealthy women at their own expense, but not to the poor with public funding: “If rich women want to enjoy their high-priced vices, that is their responsibility...that is fine, but not at the taxpayers’ expense.”⁴ This argument prevailed in Congress in 1977, when Congress readdressed the Hyde amendment. Hyde told his colleagues, “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.”⁵

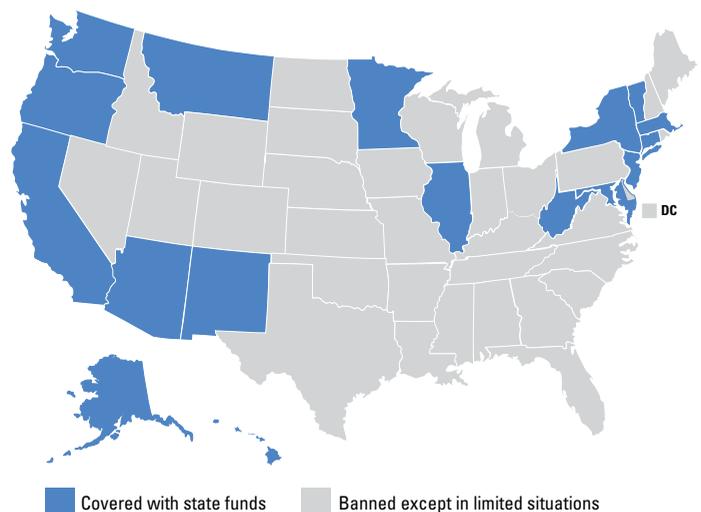
The ban on public funding for abortion was hotly debated through the rest of the 1970s, and the back and forth between the House and the Senate threatened to shut the government down more than once during that time. Meanwhile, abortion rights defenders challenged the Hyde amendment’s constitutionality in the federal courts. In 1980, the U.S. Supreme Court ruled in the landmark case of *Harris v. McRae* that the Hyde amendment is constitutional. The court held that

the funding restriction did not impinge on the right to seek abortion, writing 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 providing coverage for the costs associated with childbirth, while banning coverage for abortion) because childbearing was “rationally related to the legitimate governmental objective of protecting potential life.”

The current version of the Hyde amendment, in effect since 1997, bans federal funding for abortion, except in cases of rape, incest or where a woman’s life is threatened by “a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself.” Because Medicaid is a joint federal-state program, states may use their own funds to provide abortion coverage for Medicaid recipients, and 17 states currently do so—some voluntarily and some by court order (see map).⁶

PUBLIC COVERAGE FOR ABORTION

Seventeen states use their own revenues to pay for abortion coverage for women enrolled in Medicaid; the remaining states cover abortion only in limited circumstances, usually following the standard set by the Hyde amendment.



Source: reference 6.

Hyde's Progeny

Over the last several decades, Congress has enacted 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, including federal employees, military personnel, federal prison inmates, poor residents of the District of Columbia and Native American women (see chart).

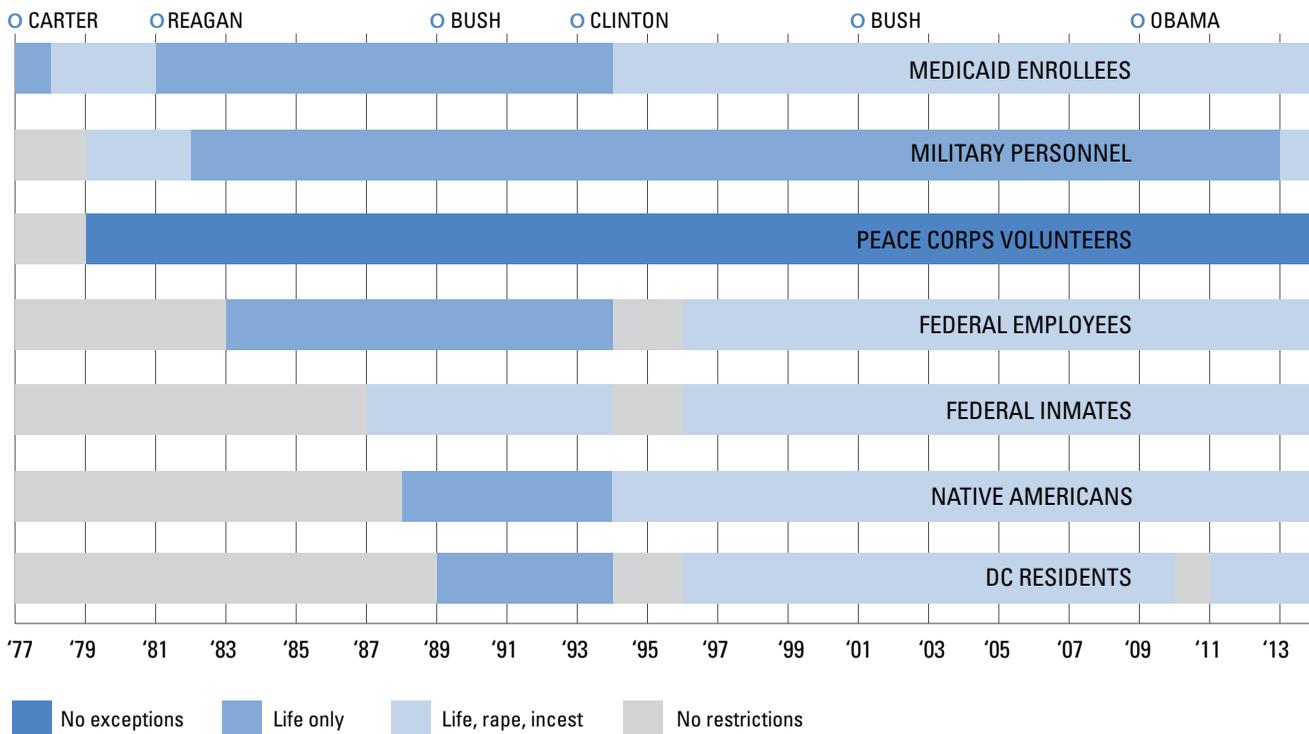
The issue over federal involvement in abortion coverage went largely dormant until the debate over health care reform got underway in the summer of 2009. Early on, President Obama and pro-choice leaders in Congress sought to tamp down the brewing controversy by asserting that health care reform should not be the vehicle for reopening the abortion debate. Instead, they asserted that the status quo should apply, which itself spawned another clash over exactly what that meant.

Abortion rights advocates reluctantly agreed to leave intact a ban on the direct use of federal funds for abortion coverage, per the Hyde

amendment, and to apply that ban to proposed federal subsidies for private health insurance. Abortion foes, by contrast, exploited this new opening to stretch radically the concept of what constitutes government funding. Indeed, they came close to winning the inclusion of the so-called Stupak amendment, named after anti-abortion Rep. Bart Stupak (D-MI), which would have banned private insurers from covering abortion for anyone in plans where any individual subscriber receives a federal subsidy under the act.

Ultimately, the Affordable Care Act (ACA), signed into law in March 2010, reflects a compromise that nonetheless created a new precedent for federal interference in abortion coverage in the private insurance market. Under the final compromise, federal funds—in this case, subsidy dollars for individuals purchasing plans on the health insurance marketplaces scheduled to be operational this fall—may not be used to pay for abortion coverage, except in cases of life endangerment, rape or incest. But insurers, at least in theory, still may offer plans that include abortion coverage,

37 YEARS OF RESTRICTIONS AND COUNTING



Note: For Medicaid enrollees in FY 1978–1979 and for military personnel in FY 1979, the law also included an exception for severe and long-lasting physical health damage.

so long as that portion of the coverage is paid for by the subscriber, not with federal funds.

In practice, however, the abortion provision in the ACA establishes some potentially high hurdles that could severely limit women's access to plans that cover abortion. To ensure the segregation of funds, insurance companies offering plans that include abortion coverage for individuals with subsidized coverage will need to estimate the cost of the coverage and issue a bill that separates this cost from the costs of all other coverage. Insurance companies will also need to maintain separate accounts and submit a plan to the state insurance commissioner that details a process to ensure that the payments for abortion coverage never mix with federal funds.⁷

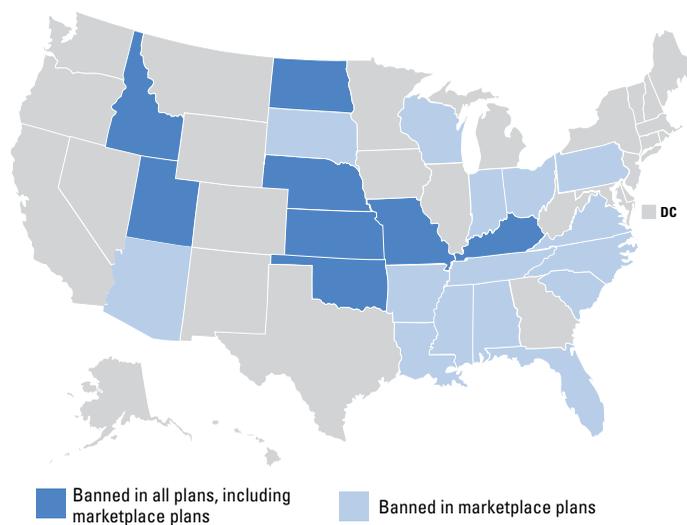
In addition, the final compromise invites states to prohibit abortion coverage in private plans outright—and many have done so. Twenty-three states have laws essentially banning abortion coverage in plans that will be offered through the health insurance marketplaces, including eight states that ban insurance coverage of abortion more broadly in all private insurance plans regulated by the state (see map).⁸ And, just like the federal government, 18 states have banned abortion coverage in insurance plans for public employees.

Insurance Coverage Matters

It is too early to know what the impact will be of these new restrictions on private insurance coverage of abortion. However, some 35 years after the initial passage of the Hyde amendment, there is a strong body of evidence on the impact of denying insurance coverage of abortion to low-income women insured through Medicaid. A 2009 literature review published by the Guttmacher Institute identified 38 studies published between 1979 and 2008 that analyzed the impact of the Hyde amendment on a range of outcomes.⁹ The review concludes that one in four women with Medicaid coverage subject to the Hyde amendment who seek an abortion are unable to obtain one due to the lack of coverage. This conclusion was based on studies from five states that compared the ratio of abortions to births before and after funding ended. The study with the best design examined abortion and birth rates in North

PRIVATE COVERAGE FOR ABORTION

Eight states have laws banning abortion coverage in all private health plans, including the new plans offered in the health insurance marketplaces; 15 additional states have bans that are limited to marketplace plans.



Source: reference 8.

Carolina, where a state abortion fund ran out of money before the end of the fiscal year on several occasions between 1978 and 1993.¹⁰ This study found that 37% of women who would have had an abortion if Medicaid coverage were available carried their pregnancy to term during the periods when funding was unavailable. (A key caveat worth emphasizing, however, is that restoration of federal Medicaid coverage would not result in a commensurate increase in the incidence of abortion nationwide, as leading antiabortion activists incorrectly have concluded; see box.)

American women who are denied an abortion struggle more financially than women who undergo the procedure, according to a study by researchers at the University of California, San Francisco, presented at the 2012 meeting of the American Public Health Association.¹⁴ The study was based on data on more than 800 women seeking abortions at 30 U.S. facilities, comparing women who received an abortion and women who were turned away because they requested an abortion beyond the provider's gestational age limit. One year later, the women denied an abortion were less likely than the women who received an abortion to be working full time and more likely to be receiving public assistance and

Insurance Coverage and Abortion Incidence

In March 2010, Rep. Michele Bachmann (R-MN) warned that insurance coverage of abortion under health care reform would result in a huge jump in the number of abortions in the United States.¹¹ “We know from the Alan Guttmacher Institute that if there is taxpayer funding of abortion, there will be 30% more abortions,” she said at a press conference. Given that an estimated 1.2 million abortions are performed in the United States each year, a 30% increase would mean an additional 360,000 abortions.

Guttmacher studies and those from other researchers on the impact of the Hyde amendment do indeed conclude that denial of abortion insurance coverage under Medicaid impedes a sizable minority of America’s poorest women from obtaining the procedure. But the claim that restoration of abortion coverage would result in a substantial increase in the nationwide incidence of abortion is not supported by the research.

This is because only a small proportion of women are enrolled in

Medicaid in any state and, therefore, affected by the Hyde amendment. It is also because 17 states—including several of the nation’s most populous, such as California and New York—already use their own money to pay for abortion services for poor women. Accordingly, lifting the Medicaid restrictions on abortion coverage would translate into an estimated 5% rise in the total number of abortions in the group of states in which funding is currently restricted.¹² The national impact of repealing the Hyde amendment would be even smaller: The number of abortions among Medicaid-eligible women nationwide would be expected to increase by approximately 33,000 if the Hyde amendment were to be repealed—or only a 2.5% increase in the number of abortions performed nationwide.

Moreover, extrapolating from Guttmacher’s Medicaid findings to assert that coverage in the private insurance market is strongly linked to abortion incidence is entirely illegitimate. It is true that, under health care reform, millions of individuals

who would otherwise be uninsured are expected to have coverage. Many private insurers, however, will simply decline to sell policies covering abortion on the health insurance marketplaces. Even for those insurers that do offer abortion coverage, there is little reason to think that such coverage would allow sizable numbers of women to obtain abortions that they cannot already afford today. The lack of abortion coverage is not nearly the impediment for higher income women as it is for low-income women. Therefore, the availability of coverage in private insurance plans, while important at the individual level, cannot be expected to substantially increase the overall numbers of abortions. In fact, in Massachusetts—a state that enacted its own universal health care plan in 2006 and provides abortion coverage for individuals with subsidized private coverage and for Medicaid enrollees—the number of abortions actually declined by 1.5% between 2006 and 2008, even as the insured population grew by nearly 6% over the same period.¹³

living below the federal poverty line—despite the fact that there were no economic differences between the two groups a year earlier.

Importantly, most low-income women with Medicaid coverage subject to the Hyde amendment manage to obtain an abortion,⁹ notwithstanding the lack of coverage—a fact that speaks to women’s determination not to bear a child or another child they feel unprepared to care for. Doing so, however, often comes at a considerable price to themselves and their families. One study published in 2013 surveyed more than 630 women obtaining abortions and found that

many are forced to divert money meant for living expenses—such as rent (14%), food (16%) or utilities and other bills (30%)—as they scrape together the funds to pay for the procedure.¹⁵ These findings are hardly surprising when put together with other studies showing that many Americans do not have adequate savings to cover a financial emergency of any kind. According to a survey conducted by the National Foundation for Credit Counseling, 46% of Americans said that if they needed \$1,000 for an unplanned expense, they would have to borrow it from friends or family; sell or pawn their personal items; or neglect paying rent, utilities or some other obligation.¹⁶

Because of the time and effort it takes to scrape together the funds, many poor women have to postpone their abortion. One study highlighted in the 2009 literature review compared the experiences of women who had abortions at a clinic in Missouri in 1977 (when Medicaid coverage for abortion was available) and in 1982 (when coverage was generally not available).¹⁷ In 1977, Medicaid-eligible women seeking abortions experienced no delay in obtaining the procedure, compared with higher income women. In 1982, Medicaid-eligible women having an abortion did so about a week later than more affluent women; among those who said they had to postpone their procedure to raise the funds to pay for it, the delay was 2–3 weeks.

These substantial delays are problematic because both the cost and risk of an abortion increase as the pregnancy continues. In 2009, the median charge for an abortion was \$470 at 10 weeks' gestation, but jumped to \$1,500 at 20 weeks.¹⁸ And the risk of complications from abortion—although exceedingly small at any point—increases exponentially with gestational age.¹⁹ Thus, a poor woman seeking an abortion 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 increases.

A Matter of Reproductive Justice

Starting in 2014, as a matter of perverse irony, more women than ever will be subject to the Hyde amendment, because the health care reform law includes a dramatic expansion of the overall Medicaid program that allows states to include all individuals with incomes under 133% of the federal poverty level (\$25,974 for a family of three²⁰). Moreover, as the health insurance marketplaces roll out this fall (selling coverage starting on January 1, 2014), it will quickly become clear how insurance plans are positioning themselves and to what extent the new norm regarding abortion coverage is veering toward exclusion, rather than inclusion.

By singling out abortion as something other than a legitimate medical procedure deserving of health insurance coverage, the government is further entrenching a two-tiered system of health

care in which low-income women do not have the same freedom to make their own decisions as those who can afford abortion. As Justice Thurgood Marshall noted in his dissenting opinion in *Harris v. McRae*, the Hyde amendment was “designed to deprive poor and minority women of the constitutional right to choose abortion.” It is a “form of discrimination repugnant to the equal protection of the laws guaranteed by the Constitution [that] marks a retreat from *Roe v. Wade* and represents a cruel blow to the most powerless members of our society.”

Indeed, the Hyde amendment and its progeny have put obstacles in the path of women seeking abortion and hurt the very people that health insurance should benefit the most. The whole purpose of health insurance is to ensure that individuals can afford unexpected medical bills in the case of an unplanned event, and unintended pregnancy—or a much-wanted pregnancy that goes horribly wrong—is the very definition of an unplanned event.

Restrictions on insurance coverage of abortion fall hardest on poor women, who are already disadvantaged in a host of other ways, including in their access to the information and services necessary to prevent unplanned pregnancy in the first place. Compared with higher income women, poor women are five times as likely to have an unintended pregnancy, five times as likely to have an abortion and six times as likely to have an unplanned birth.^{21,22} Moreover, abortion has become increasingly concentrated among poor women: In 2008, 42% of women obtaining abortions had incomes below 100% of the poverty level—a large increase from 27% in 2000.²³

Pushing for incremental improvements to current abortion restrictions to ensure coverage at least in cases of life endangerment, rape and incest is an important goal for abortion rights advocates. Yet, the original, more ambitious agenda to completely repeal the discriminatory abortion policies that pervade federal and state laws remains. The goal is that the federal government, in its role as insurer and employer, should ensure that coverage for abortion services is included in the health insurance it provides to women and arranges for

its employees and their dependents. Moreover, there should be no government restrictions that prohibit or otherwise interfere with abortion coverage in private health insurance plans.

Lifting the existing bans would validate abortion as the legal, constitutionally protected and medically appropriate health care service that it is. Every woman should have affordable and comprehensive health care coverage that includes coverage for abortion care—regardless of the type of insurance she has, her income or her zip code. In the words of Jessica González-Rojas, executive director of the National Latina Institute for Reproductive Health, abortion coverage is fundamentally a matter of reproductive health, rights and justice: “Each of us, not just some of us, must be able to make the important decision of whether to end a pregnancy. For too long, politicians have been allowed to deny a woman’s abortion coverage just because she is poor.... Together we are standing up to say ‘enough.’”²⁴

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