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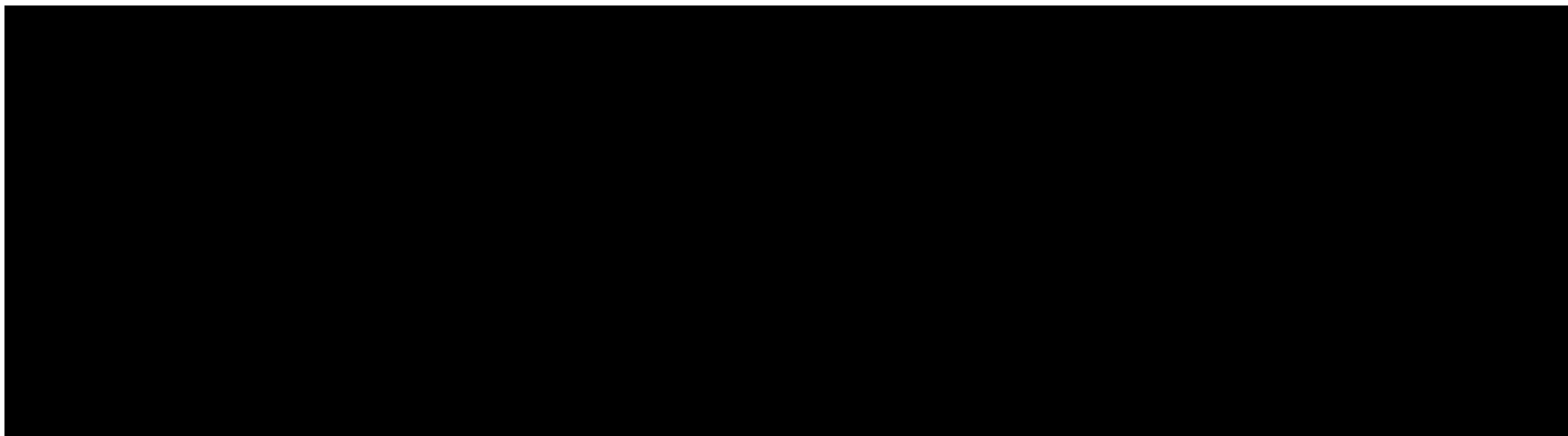

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Call Me In the Morning Call Me In the MorningCall Me in the Morning is Jezebel's sexual health column.
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I was recently asked by Whole Woman's Health Alliance, a non-profit independent abortion provider, to provide abortion care at their new health center in South Bend, Indiana, after the city had been without abortion care since 2015. Though I currently work as a provider in New York, I immediately said yes; there is a shortage of doctors who are able to provide this kind of care. I got all my licensing documentation in order and made plans to fly to South Bend.

In Indiana, I saw patients of all demographics, from mothers to young people, and college students. My patients there are prevented from using Medicaid to pay for their abortion, forcing some into difficult situations. I had a patient tell me that she had to wait several weeks until she had enough money to pay for the abortion. She worked extra shifts at the diner where she waitressed and managed to come back before the window of medication abortion (medication abortion can be taken up to 10 weeks gestational age) closed. She had health care insurance coverage through Medicaid, but that didn't matter when she needed abortion care.

Medicaid is a federal program that provides health insurance to people with low incomes. In Indiana, Medicaid can only be used to pay for abortion care in cases of "rape, incest and life endangerment of the parent." As a physician who has cared for thousands of pregnant patients who come from all walks of life, I know that there are so many reasons why someone needs abortion care. What this means is that people of low income, particularly people of color, are forced to pay out of pocket for essential health care.

Many have to work extra shifts and hours like my patient in Indiana or borrow money from friends, colleagues, or family members. Others have to turn to abortion funds to help cover the cost. A 2013 study found that a significant number of low-income women delayed paying rent, utility bills and even purchasing food in order to pay for their abortion. Plus, for many patients, it's not just the cost of the abortion procedure that they have to cover. There is also transportation, childcare, and potentially lost wages. It all adds up, and it can amount to quite a lot of money.

Transportation can be an especially big hurdle. In Indiana, 96 percent of the state's counties don't have an abortion clinic and, according to Guttmacher, 70 percent of Indiana's women live in those counties (plus, telemedicine to administer abortion medication is illegal). All of these financial pressures can put patients in a difficult position: the longer it takes to gather the money to pay for the service, the further along they get in their pregnancy, which can make the care more expensive or even push it out of reach. In the 33 states and the District of Columbia that do not allow Medicaid to be used to cover abortion services, patients in those states might have to pull together hundreds of dollars to get health care.

This policy was specifically designed to prevent people with low incomes from accessing abortion care

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Patients are unable to use Medicaid for abortion care because of the Hyde Amendment, which, this month, will have been in place for 43 years. It must be renewed yearly with the funds that are allotted by the government for public use. And every year since its passage in 1976, it has been.

Henry Hyde, the anti-abortion congressman whose name graces the bill, wanted to end all abortion care. His bill, passed just three years after *Roe v. Wade* decriminalized abortion in all 50 states, was a vehicle for restricting access. The language in the Hyde Amendment has been deeply influential; similar language has been used for other federal programs that pay for health care, including the military, federal prisons, and the Peace Corps. As a woman of color and a physician who sees patients with low incomes, it's important for me to be aware that this policy was specifically designed to prevent people with low incomes from accessing abortion care.

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Individual states can opt to cover abortion through their own Medicaid funds (the program is partially federally funded and partially state-funded), but there are only 17 states that permit Medicaid coverage of abortion care, and Indiana isn't one of those states. Quite frankly, this isn't enough. Low-income people are more likely to experience an unintended pregnancy compared to those who have resources. And people of color are more likely to be impacted by these insurance restrictions, as they are with other barriers to health care. Accessing necessary health care should not be based on your zip code or the color of your skin.

And if the person seeking an abortion is ultimately unable to receive the care because of barriers such as cost, the outcomes are exponential. The Turnaway Study found that those who are turned away from accessing abortion are more likely to live below the Federal Poverty Level, stay in abusive relationships, and experience poor pregnancy outcomes.

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People of color and organizations like All* Above All have been fighting hard to end the Hyde Amendment. The first comprehensive bill to end

Hyde was introduced in Congress in 2015 by Representative Barbra Lee, a Democrat from California. The bill is called the Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act. My colleagues at Physicians for Reproductive Health and I believe this bill would make such a huge difference in our patients' lives. This bill, if passed, would ensure that all people accessing health insurance through the government would be able to receive abortion services.

I came into medicine because I see it as my duty and the duty of other medical professionals to fight for our patient's rights to have dignity and affordable medical care. This is worth fighting in order to ensure that patients— my patients—don't have to suffer in order to receive the life-changing care that they need.

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*Dr. Meera Shah, MD, MPH, MS is the Chief Medical Officer of Planned Parenthood Hudson Peconic in New York and a fellow with the Physicians for Reproductive Health. She is currently working on a book of essays about reproductive health access.*

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