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Reproductive Freedom For All: A Policy Brief

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Part 1: Social Problem and Affected Populations

1 Scope of the Problem

The issue of reproductive rights as a valued freedom has been a source of controversy throughout history and current legislation places these rights under attack. The problem this policy brief seeks to address is the current lack of accessible reproductive healthcare and the severity to which these rights are being threatened by present-day policies, specifically regarding abortion access. From the first wave of abortion policy that erupted in the early 19th century and lasted until the mid-20th century, to the 1960s Women's Rights Movement that sparked numerous court cases and resulted in new federal legislation (i.e. *Roe v. Wade*), the status of reproductive healthcare has been placed in the hands of politicians for centuries.

1A History of the Problem

The history of policy regulation regarding reproductive healthcare in the United States dates to the 17th century. From the 1600s until the 1800s, abortion was legal and widely practiced. English common law defined "abortion" as the miscarriage or termination of a pregnancy after the "quickening stage," or, "the point at which you can feel the fetus moving in the womb" (Eastside Gynecology, n.d. para. 9). Abortions were only illegal after this stage and if the pregnancy ended before then, it was considered to have, "slipped away or the menses had been restored" (Raegan, 1997, p. 8). "Restoring the menses" was a domestic practice which utilized herbs to resume the menstruation cycle following conception (Raegan, 1997). By the mid eighteenth century abortions performed by drugs were commercialized. The service was advertised in newspapers, sold by pharmacists, and could be delivered via mail. In fact, the first restriction regarding abortion did not stigmatize its use, but rather banned certain poisons used to cause a miscarriage (Raegan, 1997). Then by 1860, 20 states had formed laws restricting abortion. From the late 19th century until the mid-20th century, several other regulations, such as the Comstock Law and statutes supported by the American Medical Association, worked to limit abortion access (Eastside Gynecology, n.d.).

The shift in societal attitudes from widespread approval and practice to a strict anti-abortion sentiment may be attributed to several factors. In 1857, the American Medical Association (AMA) was established and set out on an agenda to criminalize abortion in the United States. Physicians were motivated to establish "professional power, control medical practice, and restrict their competitors" (Raegan, 1997, p. 10). In addition to these elitist interests, discrimination existed at the core of the anti-abortion agenda. Nativism, anti-Catholicism, and anti-feminism ideologies were largely involved (Pollitt, 1997). For example, declining birth rates

among Northern European settlers led to the perpetuation of a theoretical "race suicide," in which it was feared that the immigration population, many of them Catholic, would outnumber the population of white Yankees. As for anti-feminism, according to Raegan, "women were condemned for following 'fashion' and for avoiding the self-sacrifice expected of mothers" (p. 11). In summary, the anti-abortion movement desired to maintain the domestic role of women and limit reproductive access for every race, ethnicity, and class.

Next in the history of reproductive justice in the U.S., advocacy and court cases surrounding the 1960s Women's Rights Movement laid the groundwork for abortion legislation. Beginning in the 1960s, women advocated for the expansion of reproductive rights through several methods of protest, such as "speak-outs," marches, and lobbying. During the speak-outs, "women talked publicly for the first time about their illegal abortion experiences" (Baker, 2020, para. 11). From these speak-outs it became evident that pregnant people were going to obtain abortions, whether it was safe, legal, or not. In addition to advocacy efforts, court cases in the 60s and 70s challenged abortion restrictions. In 1965, the Supreme Court ruled in *Griswold v. Connecticut* that the states do not have the right to ban the use of contraception for married couples. From a legal standpoint, this decision was monumental because it established the first, "constitutional right to privacy regarding reproductive decisions" (Planned Parenthood, 2021, para. 2). Next, in 1972, it was determined in *Eisenstadt v. Baird* that states could not prohibit the distribution of contraception to unmarried adults (Brennan & Supreme Court of the United States, 1971). These factors, in addition to the relaxing of some state laws regarding abortion, led up to the precedents established in *Roe v. Wade*.

The most influential court decision to influence reproductive rights is *Roe v. Wade.* Passed on January 22, 1973, the decision put an end to a Texas statue that banned abortions and legalized access across the United States (Blackmun & Supreme Court of the United States, 1972). *Roe,* the lead opinion, argued that "the right to privacy was broad enough to encompass a woman's decision whether to terminate her pregnancy" (Ziegler, 2020). In addition, *Roe* expanded the right of choice to other aspects of healthcare, such as, "marriage, childbirth, parenting, and family" (Ziegler, 2020). In the final decision, the court ruled that the right to an abortion is a "natural extension" of the existing privacy clause (Blackmun & Supreme Court of the United States, 1972).

The court divided pregnancy into three trimesters. In the first trimester, the choice to terminate a pregnancy is left only to the mother. In the second, government intervention is permitted but complete banning is not. Finally, in the third trimester, states have a right to propose regulations or even ban abortions (Blackmun & Supreme Court of the United States, 1972). The ruling of *Roe v. Wade* was revolutionary because for the first time since the 19th century, abortion was

legal across the United States. Not only was this a huge victory for the people who advocated for its legalization, but for the millions of others who had undergone illegal abortions and thousands who had died during them (Gold, 2003). To this day, *Roe v. Wade* has expanded and protected reproductive justice in the United States.

1B Present Status of the Problem

Today, one in four women in the United States will terminate a pregnancy at some point in their life (Keller & Sonfield, 2019). This statistic accounts for several methods of abortion, including medication and surgical. Medication abortions are permitted up to 10 weeks' gestation and, "account for almost one in three nonhospital abortions" (Keller & Sonfield, 2019). In addition, both forms of abortion include services such as counseling, ultrasounds, and follow-up care. According to the most recent data published by the Ohio Department of Health, 18,193 abortions were performed and obtained by residents in 2019. The demographic makeup of this group was reported as follows: 1 in 9 women who received an abortion were under the age of 20; 29% were between the ages of 20-24 years; 86% with known marital statuses were never married, divorced, or widowed; and 14% were married or separated (Paulson & Smith, 2020). Also, 46% of women who obtained an abortion were white, 46% were African American, 4% were Asian/Pacific Islander, 6% were Hispanic, and 4% were more than one race (Paulson & Smith, 2020). From these demographic statistics, we can deduce that the need for abortion services affects all, no matter their age, marital status, or race.

According to the Guttmacher Institute, in 2017 there were 1,587 facilities which offered abortion services in the United States, a 5% decrease from the 1,671 facilities in 2014 (2021). 60% of the abortions obtained in 2017 were performed at abortion clinics, which are defined as clinics where more than half of all patient visits are for abortion (Guttmacher Institute, 2021). In Ohio, there were a total of 14 facilities providing abortion care in 2017, 9 of those being clinics (Guttmacher Institute, 2021). This demonstrates a 25% decrease in clinics since 2014, when there were 17 functioning abortion facilities and 12 of those were clinics. To put these statistics into perspective, in 2017 approximately 93% of Ohio counties did not have any clinics that provided abortions and 55% of women residents lived in these counties (Guttmacher Institute, 2021). Nationally and in the state of Ohio, the number of available abortion clinics have and continues to decrease at an alarming rate. These dropping numbers reflect a widespread scale back of abortion accessibility.

1C Populations Affected

According to the U.S. Census Bureau, women make up 50.8 percent of the population (2015-2019). However, the fight for reproductive rights does not just affect cisgender women, or women "whose gender identity aligns with those typically associated with the sex assigned to them at birth" (Human Rights Campaign, n.d., para. 6). The census is limited in that it possesses only two categories for gender, male and female, and does not account for transgender, intersex, non-binary, and gender non-conforming individuals. Therefore, the population of those seeking reproductive care and abortion access in the U.S. is greater than this survey accounted for. When discussing the issue of reproductive and abortion access, it is essential to utilize gender-neutral language, such as a "pregnant person" as opposed to a "pregnant woman" (Forward Together, 2021). As mentioned previously, this is purely because not all people who seek abortions fit into the cisgender woman demographic. In fact, according to a study performed by the Guttmacher Institute, it was found that between 462 and 530 transgender and non-binary patients received an abortion nationwide in 2017 (Jones et al., 2020). However, as demonstrated by the U.S. Census Bureau, many statistic databases use the term "woman," due to "current limits of data collection as it relates to gender identity" (Forward Together, 2021, para. 8). Throughout this policy brief, it was attempted to use gender non-conforming language whenever applicable. However, to maintain the integrity of direct quotations from sources, this was not always possible.

While over half of the U.S. population suffers from a lack of accessible reproductive healthcare, special attention must be given to several disadvantaged groups who are faced with additional issues associated with inequality. It is important to note that individuals who are a part of one disadvantaged group often intersect with other forms of inequality. This results in several disparities concerning accessibility, especially regarding reproductive care (Keller & Sonfield, 2019). For the low-income community, the cost of reproductive healthcare may be unaffordable, leading patients to one of these outcomes: denial of the service, placement in debt, or sacrifice of another necessity. For example, individuals who are of low-income and wish to pursue an abortion, are often "forced to forgo or delay basic expenses such as rent and food to pay for the direct and indirect costs of the procedure (e.g. lost wages, transportation, and childcare)" (Keller & Sonfield, 2019). For people who give birth, "the average out-of-pocket cost for maternity care is approximately $16,500, more than half the average income for a woman of reproductive age" (Keller & Sonfield, 2019).

As explained previously, racial and ethnic disparities in abortion access often intersect with economic inequalities. However, people of color are faced with the additional layer of structural racism in all forms of healthcare, including reproductive care (Keller & Sonfield, 2019). These inequalities in reproductive

healthcare are reflected in the mortality, morbidity, and unintended pregnancy rates for Black and Hispanic women. Contrary to the data presented in the Ohio Department of Health's report, nationally, "the abortion rate for black women is almost five times that for white women" and the abortion rate for Hispanic women is double the rate of white women (Cohen, 2008). In addition, Black women experience the most unintended pregnancies than any other demographic and Hispanics have the highest rates among low-income women (Cohen, 2008). The solution, then, to address and reform socioeconomic and systemic racial disparities in abortion access and services is to increase the accessibility of effective contraception. According to the Guttmacher Institute, "As of 2002, 15% of Black women at risk of unintended pregnancy (i.e. those who are sexually active, fertile and not wanting to be pregnant) were not practicing contraception, compared with 12% and 9% of their Hispanic and white counterparts" (Cohen, 2008). Studies researching the reasons why individuals of these affected demographics do not use contraceptives found geographic access, lack of affordability of the most effective methods, and life events to be the most influential factors (Cohen, 2008).

Part 2: Current Policy and Pros and Cons

2 Current Policy

Since reproductive freedom encompasses a wide range of issues, there are numerous policies set in place that regulate its current state in the U.S. A report completed by the Guttmacher Institute titled, "More to Be Done: Individuals' needs for Sexual and Reproductive Health Coverage and Care," breaks down the issue of reproductive healthcare into several categories (Keller & Sonfield, 2019). These categories include contraceptive care, abortion, maternal and newborn health, infertility, reproductive cancers, sexual or intimate partner violence, HIV/AIDS and other STIs, and additional sexual and reproductive health needs. The source evaluates the present state of each of these areas and addresses where they require improvement. While each of these needs are essential to reproductive health, in the proceeding paragraphs we will focus on the current policies regulating contraceptive care and abortion access. A major policy regulating contraception is the federal contraceptive guarantee under the Affordable Care Act of 2010 (ACA). In addition, current policies regulating abortion access include the federal Hyde Amendment and state-wide abortion bans and restrictions.

2A Origin and Intent of the Current Policy

The ACA was signed into law on March 23, 2010 by President Barak Obama. The main goal of this piece of legislation was to move the attention of health care and insurance providers "away from reactive medical care toward preventive care," including the preventive care of contraception (Tschann & Soon,

2015). After the signing of the ACA, the Department of Health and Human Services (HHS), "tasked the Institute of Medicine (IOM) with determining which services should be included as preventative health care services under the ACA" (Tschann & Soon, 2015). The IOM met with the Committee on Preventive Services for Women, and in 2011 the committee released a list of recommendations of services that should be covered by the ACA. The list included, "the full range of Food and Drug Administration (FDA) approved contraception methods" (Tschann & Soon, 2015). The HHS adopted these recommendations, among others, and began their implementation in August 2012.

The passage of the ACA and the contraceptive guarantee is a milestone in terms of reproductive freedom in the United States. Although many private insurers already included contraceptive care in their coverage, the ACA removed additional costs that have statistically barred some from obtaining access to contraception. In addition, the federal guarantee includes coverage of eighteen forms of contraception, providing individuals with the option to choose the contraception method that best suits their needs (Guttmacher Institute, 2021). Considering the statistics regarding the widespread use of contraception in the U.S., this piece of legislation largely expanded and maintains access to a greater population. Not only this, but the act established contraceptive care and reproductive healthcare as an imperative preventative measure.

Three years after the ground-breaking *Roe v. Wade* Supreme Court case, Congress passed the first Hyde Amendment and set out its application to the fiscal year 1977 appropriation of Medicaid (ACLU, 2021). The legislation was introduced by Congressmen Henry J. Hyde and, "barred the use of federal Medicaid funds for abortion except when the life of the women would be endangered" (ACLU, 2021). Implementation of the Hyde Amendment was blocked for almost a year by the Reproductive Freedom Project, the Center for Constitutional Rights, and Planned Parenthood, but the injunction ended in August 1977 (ACLU, 2021). Once the Hyde Amendment was implemented, abortion funds financed by Medicaid fell from about 300,000 per year to a few thousand (ACLU, 2021). Since then, the Hyde Amendment has been passed every year to date, with rape and incest exceptions included in several fiscal years (ACLU, 2021).

The present-day implementation of the Hyde Amendment is very harmful to people who get pregnant, especially to people of the low-income community. According to Ohio.gov, individuals who qualify for Medicaid in Ohio include people with low-income and pregnant women, infants, and children, among other demographics (2021). In addition, those who apply for Medicaid must meet the program's financial eligibility requirements. Therefore, since a requirement of receiving benefits from Medicaid is to make a specified monthly income below the federal poverty level, all recipients are members of the low-income community.

Also, according to the most recent data provided by the Kaiser Family Foundation (KFF), a nonprofit organization focusing on U.S. health issues, 36% of the Medicaid population is made up of women (2019). Since individuals who are low-income already require assistance, it would be almost impossible for them to afford an abortion without funding from Medicaid. Not only does the Hyde Amendment limit abortion access, but it jeopardizes the reproductive healthcare of people of low-income.

Finally, present-day abortion bans and restrictions passed at the state-level are, by-far, the greatest threat to abortion access and reproductive freedom. In fact, "Since 2011, states have enacted 424 new abortion restrictions, many of which conflict with scientific evidence" (Keller & Sonfield, 2019). Unfortunately, policy regulating abortion access in the state of Ohio is currently very limited and the future does not look good. In the state of Ohio specifically, targeted regulation of abortion providers (TRAP) laws, bans (gestational ban, method ban, and reason ban), and restrictions (transfer agreement requirement, reporting requirement, parental involvement, and so on) regulate when, why, and how women can receive an abortion (Center for Reproductive Rights, 2021). If *Roe v. Wade* or the Hyde Amendment are weakened or overturned in the future, Ohio legislators will most likely seek more extreme legislation to limit abortion access.

2B Structure and Function of Current Policy

The federal contraceptive guarantee under the ACA was the first piece of legislation to mandate preventative coverage requirements for contraceptive care under all health insurance plans in the United States; including individual, small group, large group, and self-insured programs (KFF, 2019). Since 2012, the ACA has required insurance networks to cover many forms of contraception, today eighteen, in addition to counseling services. However, the most influential aspect of the federal guarantee prevents insurance companies from charging co-payments, deductibles, or other cost sharing. Due to mounting evidence that co-payments create barriers for women attempting to obtain contraception, this portion of the policy is especially significant (Tschann & Soon, 2015). Numerous studies have revealed that, "with counseling and removal of logistical and financial obstacles, such as prohibitive cost-sharing, most women will choose the most effective methods of contraception," since they finally have access to it (Tshann & Soon, 2015).

Nationwide, the Hyde Amendment "bans the use of federal funds for abortion under Medicaid except in limited circumstances," granting reproductive freedom only to those who are financially capable (Keller & Sonfield, 2021). Today, these limited circumstances include cases of rape and incest, however, exceptions to the funding ban have changed since the legislation's original passage

in 1977. For example, in 1980, the Supreme Court case Harris v. McRae upheld the constitutionality of the original Hyde Amendment, containing a single exception in the case of life endangerment. From the second half of the fiscal year 1981 until 1993 this single exception was maintained (ACLU, 2021). In 1994 the exception of rape and incest was once again added to the policy. The Hyde Amendment is considered a temporary "rider" to Congress' annual appropriations bill for HHS, as opposed to a permanent policy. During the 2016 and 2020 presidential elections, the Hyde Amendment was a prominently debated issue, with President Joe Biden calling on Congress to remove the stipulation from their appropriations (ACLU, 2021). However, this would require a vote by Congress to not reenact the amendment.

According to the Center for Reproductive Rights, Ohio bans abortions twenty-weeks after a women's last menstrual period (LMP), although there have been additional bill proposals to move this ban up to six weeks LMP (2021). This is known as a gestational ban. In addition, the state prohibits dilation and extraction (D&X) and dilation and evacuation (D&E) procedures (method ban) (2021). A woman seeking an abortion is required to receive state-directed counseling that takes place in-person and consists of information designed to deter the patient from having an abortion (Guttmacher Institute, 2021). After the biased counseling requirement occurs, there is a twenty-four-hour waiting period before the patient can receive the service. Minors are required to receive consent by a parent or legal guardian in order to obtain an abortion (Center for Reproductive Rights, 2021). Ohio targeted regulations of abortion providers (TRAP) laws impose civil and legal penalties on medical providers who violate Ohio abortion restrictions. These restrictions include reporting requirements and "ambulatory surgical facilities" to have "written transfer agreements with a hospital" (Center for Reproductive Rights, 2021). The bans and restrictions listed and described above are a few of the major state-level policies currently in effect which limit abortion access in Ohio.

2C Pros and Cons of Current Policy

Since the implementation of the federal contraceptive guarantee under the ACA, studies have highlighted several benefits as far as increased access to contraception for women. For starters, for women with private insurance, contraception costs have dropped significantly. According to research performed by the Guttmacher Institute, "the proportion of privately insured women paying out-of-pocket costs for oral contraception decreased from 85% in the fall of 2012 to 33% in spring 2014" (Tshann & Soon, 2015). In addition, in 2013 the estimated savings due to the contraceptive guarantee totaled more than $483 million (Tshann & Soon, 2015). As stated previously, research has revealed out-of-pocket costs as being the greatest barrier for women attempting to receive contraception (Tschann

& Soon, 2015). Not only has the ACA knocked down these barriers but has resulted in millions of dollars of savings.

Another aspect of the ACA that has resulted in greater reproductive access is the "loosening of eligibility requirements for Medicaid family planning services," including contraceptive care (Tschann & Soon, 2015). The ACA expanded its eligibility to applicants making up to 138% of the federal poverty level (FPL), an improvement from the previously state-determined financial eligibility requirements. However, the Supreme Court later decided that within the ACA, the federal government is not authorized to require states to expand their Medicaid programs. Despite this implication, 29 states and the District of Columbia adopted the Medicaid expansion as defined by the ACA since 2015 (Tshann & Soon, 2015). A 2011 analysis predicted that states without an expanded Medicaid provision "could serve up to 100,000 women each and save between $2.3 million and $17.4 million dollars per year," if they were to create a program (Tschann & Soon, 2015).

The ACA, including the federal contraceptive guarantee have proven to be very controversial on opposing sides of the political spectrum. In fact, since 2010 states, private entities, and individuals have challenged specific provisions, such as the federal contraceptive guarantee, and the entirety of the ACA about 2,000 times (National Conference of State Legislatures, 2021). At the time that the academic journal "Contraceptive Coverage and the Affordable Care Act" was written in 2015, a total of 101 recorded cases had been filed against the contraceptive guarantee mandate. These challenges cite, "an infringement of the religious freedom guarantees of the First Amendment and of the Religious Freedom Restoration Act of 1993 (RFRA)" (Tschann & Soon, 2015). The entities filing these lawsuits believe that the mandate to provide contraceptive care is a violation of the religious freedoms established by these pieces of legislation.

The concerns of those opposed to the contraceptive mandate due to religious reasonings illustrate a difficult tension between religious freedom and privacy rights. The First Amendment and the Freedom Restoration Act of 1993 specifically protect the right to exercise religious freedom and the lack of government infringement on these rights (Tshann & Soon, 2015). Therefore, from a legal standpoint the lack of religious protections was a serious flaw in the contraceptive guarantee; however, the HHS responded to these challenges through modifications of the contraceptive mandate. In 2012, the HHS determined that religious institutions that are "primarily houses of worship," are not required to provide contraceptive coverage in their insurance plans. Generally, this includes the insurance plans of employees of churches, synagogues, and other places of worship. However, challenges to the mandate remain today, especially since the determination made by the HHS did not include exemptions for organizations and

institutions affiliated with a religion (i.e. universities and hospitals) (Tschann & Soon, 2015).

2D Concluding Paragraph

While the social problem of women's reproductive justice branches off into several different categories, this policy brief analyzes current legislation regulating contraceptive care and abortion access at both a nationwide and state-wide level. This analysis includes the federal contraceptive guarantee under the Affordable Care Act (ACA) of 2010, the Hyde Amendment, and Ohio bans and restrictions on abortion. Since the passage of the ACA, the contraceptive guarantee has required all insurance plans to cover contraceptive care without additional out-of-pocket costs, opening the door to increased access to contraceptive care for all women. In addition to greater access, benefits of the federal contraceptive guarantee have resulted in lower-costs and savings for women taking contraception and the government itself, a better quality of care, and the expansion of coverage through state Medicaid programs. The greatest downside of the contraceptive provision under the ACA is the controversy surrounding whether the policy infringes on religious freedoms guaranteed in the First Amendment and RFRA. The HHS did find the ACA to be wrongfully violating these religious freedoms and amended its policy, yet reservations regarding the contraceptive guarantee still exist today.

Part 3: Policy Proposal and Opposition

3 Policy Proposal

The primary purpose of this policy brief is to recognize the present status of women's reproductive rights as a valid and relevant social issue needing of urgent reform. Secondly, I hope to leave the reader with an increased compassion for this issue and encourage them to seek legislation that supports and expands reproductive justice. Since this topic is quite expansive, this policy brief will focus on one core proposal pertaining to women's reproductive rights. The most controversial aspect of women's reproductive healthcare in which policy reform is necessary is abortion access. Between the Hyde Amendment, lack of guaranteed coverage in the private sector, and hundreds of restrictions regulating its use in the states, abortion access in the United States is currently under attack. On the path to reform, Congress members should support to repeal the Hyde Amendment and enact policy that permits the use of federal funds for abortion care under Medicaid, such as the Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act.

3A Policy Proposal Supported

Upon abolishment of the Hyde Amendment, a piece of legislation that has the potential to expand reproductive justice in the U.S. is the EACH Woman Act.

First introduced by the 114th Congress, the bill would establish the responsibility of the federal government in providing abortion coverage and care for all women, no matter their race, income, or insurance plan (or the lack thereof). According to the text of the EACH Woman Act, the federal government would "ensure coverage for abortion care in public health insurance programs including Medicaid, Medicare, and the Children's Health Insurance program" (Congress.gov, 2019). It would also ensure coverage to the beneficiaries of employer insurance plans and accessible care to women at abortion providing facilities. Not only was this bill introduced in the House by representatives Barbara Lee (D-CA), Jan Schakowsky (D-IL), and Diana DeGette (D-CO), but it was also introduced in the Senate. Since it was introduced on March 13, 2019, no other action has yet been taken (Congress.gov, 2019). Advocated by groups and organizations such as Planned Parenthood, the National Partnership for Women and Families, and the National LGBTQ Task Force Action Fund, the EACH Woman Act has mounting support.

The legislation that the EACH Woman Act would take the place of is the Hyde Amendment. As described previously in the "Current Policy" section, the Hyde Amendment prevents the funding of abortion services in Medicaid, except in cases of life endangerment. In this case, the EACH Woman Act would directly address the inequalities fostered by the Hyde Amendment by mandating the allocation of funds for public health insurance networks. Not only this, but it would require abortion service coverage no matter the reasoning. In the Pros and Cons section, we will discuss those inequalities produced by the Hyde Amendment and how the EACH Woman Act has the ability to put them to an end.

3B Opposition to the Policy Proposal

With outspoken support of the EACH Woman Act mostly originating from pro-choice organizations, the most prominent opponents are anti-choice groups and their members. The term "pro-choice" encompasses the organizations and individuals who support abortion legalization, while anti-choice or "pro-life," refers to those who oppose abortion (Piper, 2020). Although these definitions appear to be black-and-white, many groups and people may associate themselves with one of these identities, but their beliefs may lie somewhere on a spectrum. At the same time, there exists those who lie at the extremes. For example, Planned Parenthood who is pro-choice and National Right to Life who is anti-choice. Listed on the "National Right to Life" website is a brief description of the proposed bill and the organization's proclaimed opposition to the EACH Woman Act (2019). Whether labeled with antichoice or not, people and organizations who do not support some or all forms of abortion for whatever reason, most likely oppose this bill. This is due to the fact that the EACH Woman Act expands reproductive freedom; the opposite of what anti-choicers want to accomplish.

3C Pros and Cons of the Policy Proposal

The EACH Woman Act has several potential positive outcomes. Since one of the main objectives of the bill is to expand abortion coverage to women who are on Medicaid, the EACH Woman Act possesses the ability to address and eradicate disparities in abortion access for women of color and low-income. Data reveals that "Of women aged 15-44 enrolled in Medicaid in 2017, 55 percent lived in the 35 States and the District of Columbia that do not cover abortion" (Congress.gov, 2019). These percentages equate to roughly 7.3 million women who lack abortion coverage. Being that Medicaid assists individuals who are in financial need, the low-income community is often targeted. In addition, according to the findings of the EACH Woman Act, "32 percent of Black women and 27 percent of Hispanic women aged 15-44 were enrolled in Medicaid in 2017," as opposed to 16 percent of white women (Congress.gov, 2019). Through the expansion of abortion coverage to public health insurance programs, the EACH Woman Act would address and eliminate these racial and class disparities. This legislation encourages the idea that abortion services are a basic and essential form of healthcare and that all women deserve this opportunity, not just those who are privileged enough to afford it.

Another potential pro of the EACH Woman Act is the promise of abortion coverage in the private sector. In addition to expanding coverage to Medicaid recipients, the EACH Woman Act would "prohibit states and the federal government from interfering in private insurance coverage of abortion, including in the health insurance marketplaces established under the ACA" (Donovan, 2019). Presently, 26 states have laws which restrict abortion coverage in private insurance plans (Congress.gov, 2019). Through the EACH Woman Act, national, state, and local governments would not be able to block private insurance networks from providing abortion care. In the face of statewide ACA marketplace bans and the efforts of antiabortion activists to pursue restrictions at the federal level, this proposed legislation would ensure abortion coverage to both public and private insurance networks.

The cons of the EACH Woman Act come from the opponents of the bill: anti-choicers. As opposed to having specific problems with this piece of legislation, discontent from anti-choice members and organizations lie in a clash of values. Remember, those who define themselves as pro-life or anti-choice do not support abortion legislation. Although individual people and organizations might vary on the reasoning for their position, in general they believe that "all human life is created equal regardless of size, level of development, education, and degree of dependency" (Piper, 2020). Therefore, their position against abortion is due to their stance that it violates the "right to life" of unborn children. According to the Gallup poll, 49% of Americans identify themselves as pro-

life (Saad, 2007). Despite this, only a small percentage of the population are fixed at the extremes of these labels, with 26% believing abortion should be legal in all cases and only 18% believing it should be illegal in all cases (Saad, 2007). At the extreme end of the anti-choice position, those individuals and organizations might view the EACH Woman Act as a direct threat to their value system.

On the flip side, most Americans do not exist at these pro-choice and pro-life extremes, but rather somewhere in the middle. In the same poll it was found that "6 in 10 (58%) Americans think abortion should be either limited to only a few circumstances or illegal in all circumstances," yet "4 in 10 (41%) think it should be legal in all or most circumstances" (Saad, 2007). These statistics reveal that most Americans opt for abortion services but only in certain circumstances. Unfortunately, this means that the public would most likely support legislation that limits abortion access, such as the present-day Hyde Amendment. Again, to those who lie in middle of the spectrum, a bill such as the EACH Woman Act might contradict with their beliefs regarding the circumstances in which abortions may be appropriate. Therefore, with a lack of support from the anti-choice extreme and middle ground, the EACH Woman Act may struggle in its path to fruition.

Despite these cons, the EACH Woman Act is still the best solution to the inequalities produced by the Hyde Amendment. The decision of choosing to receive an abortion is a difficult yet personal one. Whether the issue of abortion aligns with an individual's beliefs or not, ensuring the opportunity for all women to make this decision for themselves promotes freedom of choice. Not only this, but it promotes this reproductive freedom for women equally. Maintaining the Hyde Amendment not only would further disproportionately deny coverage to low-income women and women of color, but it would continue to entertain the notion that the government has the power to restrict women's reproductive rights. Rather, the enactment of the EACH Woman Act would, no matter the individual's perspective on abortion, ensure all women with personal autonomy over their reproductive healthcare.

3D Conclusion

A piece of legislation that has the potential to rectify the damages of the Hyde Amendment and expand abortion access in the United States is the EACH Woman Act. The primary goals of this bill are to ensure coverage to women who are on Medicaid, and prevent the federal and state governments from imposing restrictions on abortion in private insurance networks. The strongest opposition to this bill would come from pro-life or anti-choice individuals and organizations because their goal is to prevent the legalization of abortion as much as possible. The possible pros if this bill were to be enacted include the abolishment of disparities in abortion access for low-income women and women of color and the assurance of coverage in both the public and private sectors. The cons include the

violation of values of anti-choicers and those with a middle ground stance in addition to the probable hardship that will be experienced in passing this bill due to the lack of support. Considering both the pros and cons, the decision in which eliminates abortion coverage disparities and ensures reproductive freedom for all women is the pursuit of the EACH Woman Act.

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