Lights Out on Abortion

BY MELANIE CONKLIN

At 3:00 in the afternoon on May 20, Dr. Dennis Christensen, dressed in surgical scrubs, is standing outside his operating room and staring at the fax machine. Following his gaze are some twenty patients, seated in the teal chairs of the waiting room at the Madison Abortion Clinic.

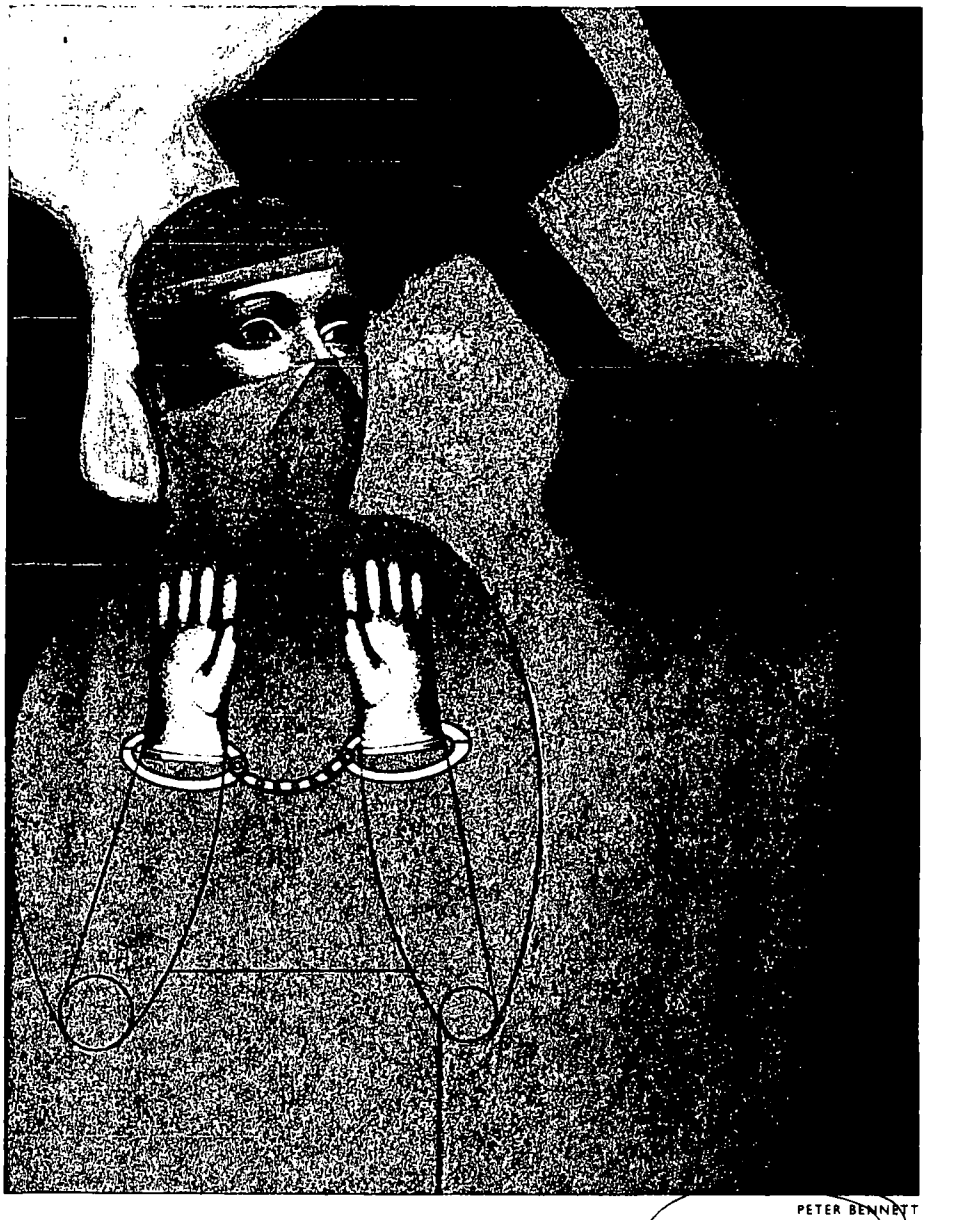
"I've been here since 10:30 this morning and I have twenty-seven patients who are becoming more agitated and anxious as the day goes on," says Christensen. "I'm quite sure the people causing this do not understand what these women are going through."

Christensen has not performed any abortions all day. He is not alone. Almost every abortion provider in Wisconsin has postponed procedures.

The previous night, Christensen conferred with his family and decided that he couldn't risk continuing his practice unless the district attorney assures him in writing that she will not prosecute him for doing first-trimester abortions. That's why he's at the fax machine.

For two days in May, the lights went out on abortion in Wisconsin. The reason: The state had passed a ban on "partial-birth" abortions that was so broadly written and so punitive—mandatory life imprisonment

Melanie Conklin is a staff writer at Isthmus, the weekly newspaper of Madison, Wisconsin. She wrote "Blocking Women's Health Care" in the January issue.



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for doctors—that virtually every abortion doctor in the state chose not to risk violating it.

The shutdown in Wisconsin shows just how far-reaching the ban on "partial-birth" abortions can be. Pro-choice advocates have long maintained that such vague state laws are actually a tool to one day ban all abortions. In May in Wisconsin, that day came closer than many thought possible.

The Wisconsin law, closely modeled on the federal bill, defines a "partial-birth" abortion as "an abortion in which a person partially vaginally delivers a living child, causes the death of the partially delivered child with the intent to kill the child, and then completes delivery of the child."

Twenty-eight states have passed laws banning "partial-birth" abortions. But the Wisconsin statute is, in many ways, the most extreme. Mandatory life imprisonment is by far the severest punishment under any state law. (Many states mimic the two-year prison sentence stipulated by the federal version, which President Clinton has vetoed twice.) The Wisconsin law specifically states that life begins at conception and does not distinguish between abortions before and after viability. And it provides no exception to women who are victims of rape or incest.

Planned Parenthood went to court to prevent the implementation of the law. But on May 14, U.S. District Judge John Shabaz refused to issue a temporary restraining order. In his decision, he referred to the "harm to the parents of those perhaps several hundred living post-first-trimester children who may be unnecessarily killed." It was the first time, after sixteen challenges nationwide, that a judge allowed such a law to take effect. The ruling, which a panel of the Seventh Circuit Court of Appeals refused to overturn, caused Wisconsin's National Organization for Women to declare, "Wisconsin overturns *Roe v. Wade*."

"These laws have passed in more than half the states now, but they are being enjoined and overturned," says Planned Parenthood of Wisconsin's spokeswoman Chris Korsmo. "This is the first time a restraining order or an injunction has been sought and denied. It put us on the front line nationwide, and not in a way we want to be there."

For two days after the appeals court decision, just about every abortion clinic in Wisconsin was out of business. This presented a hardship to many women. "These girls are absolutely demoralized," said a woman named Nancy, who accompanied a young female relative to the Madison Abortion Clinic. "Some had to borrow cars and make up stories to come in here, and they may not be able to do it again tomorrow." Others, like her relative, scheduled a fall-back appointment in Illinois for the following day.

"I'm already nervous and a little scared, and not knowing just makes it much worse," said one patient at the clinic who wished to remain anonymous.

In Wisconsin, the anti-abortion lobbyists knew what they were doing. They wanted the most sweeping bill they could get, so they helped defeat amendments that would have specifically banned only the dilation and extraction procedure, where the skull is punctured while in the birthing canal and the fetus is removed intact.

Given what was at stake, pro-choice forces seemed caught off guard. "I think a lot of people would agree with me that the pro-choice community did not respond quickly enough," says Amalia Vagts, who lobbied against the law in the Wisconsin legislature for Planned Parenthood. "But it's hard with the massive confusion over the term 'partial-birth abortion.'"

Once the bill made it to the floor, it became clear the legislation would easily pass. And Republican Governor Tommy Thompson had vowed to sign it into law, so pro-choice advocates could see the writing on the wall.

In six states where "partial-birth" abortion laws have taken effect (Indiana, Oklahoma, Mississippi, South Carolina, South Dakota, and Tennessee), pro-choice advocates chose not to challenge them in court. They based that decision on the records of the judges in their areas and on the fact that their resources were already spread thin.

By July 1, Kentucky and West Virginia are also likely to have "partial-birth" abortion laws in effect.

Many usually pro-choice legislators have voted in favor of these laws in Congress and in statehouses around the country. "The focus is now on the baby, which is where Planned Parenthood hasn't wanted it to be all these years," says Susan Armacost, legislative director for Wisconsin Right to Life. "And the result is that, here in Wisconsin, we have pro-life and pro-choice legislators banding together to pass that bill."

The public, which largely supports keeping abortion legal, also seems to favor the "partial-birth" abortion bans. Abortion-rights advocates say many people believe the bans target only late-term abortions or only a specific procedure.

But extending a ban beyond the dilation and extraction procedure is part of the strategy of anti-abortion forces. Douglas Johnson, the legislative director for the National Right to Life Committee, says the protection of abortion granted by *Roe v. Wade* is based on the location of the fetus. Once any part of a breathing or heart-beating fetus is outside the woman, it has a right to full legal protection, he says. "This is no longer in the sphere of *Roe v. Wade*," he argues. "This is an alive and living person. If the same baby is expelled spontaneously and is gasping for breath and someone picks the baby up and dashes its head against the wall, would that be a crime? I'm sure that it is."

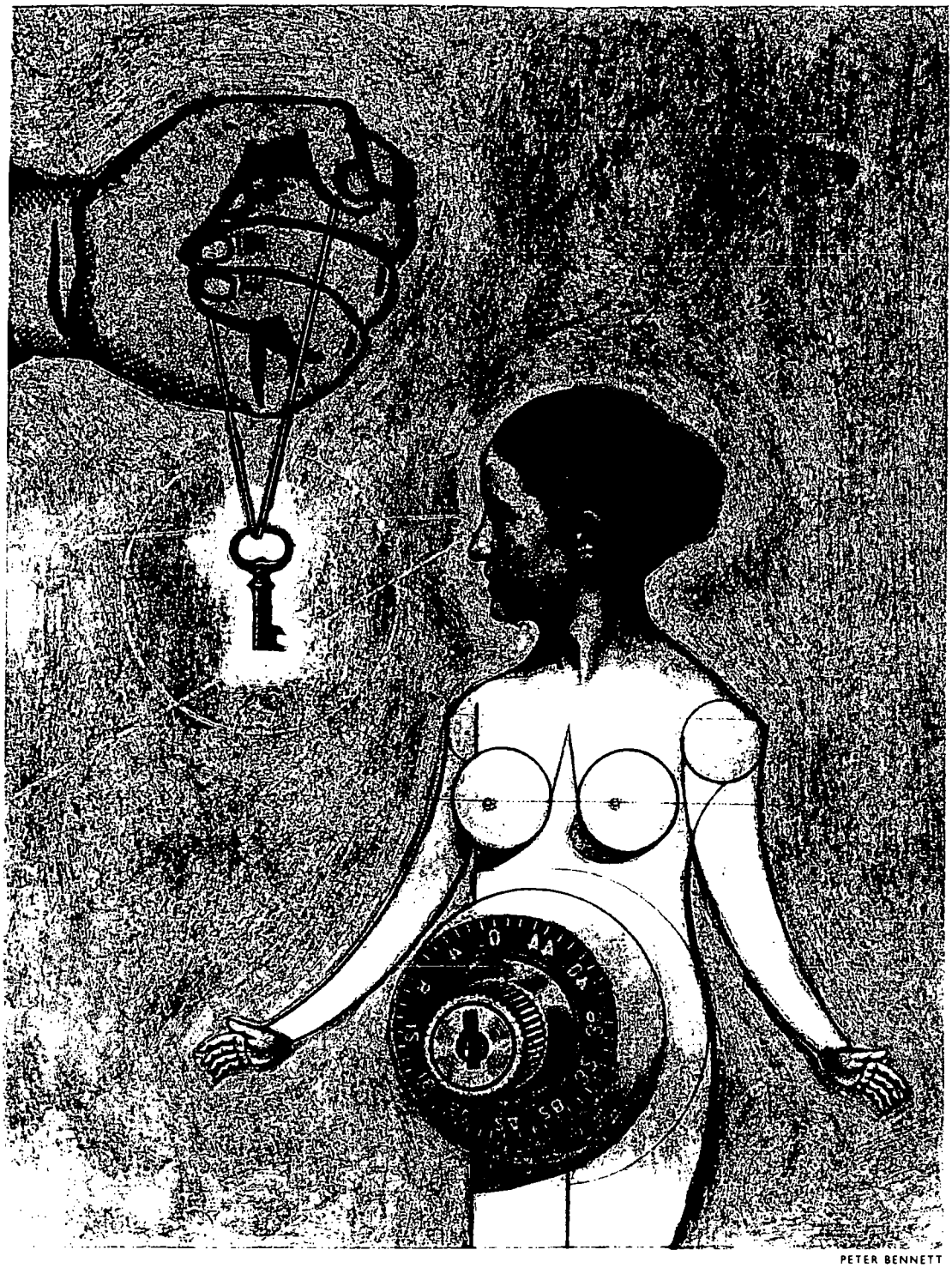
But abortion-rights advocates don't buy that argument. They say the ban could apply to most abortions. "The elements of this crime are the elements of abortions, namely that the fetus comes out through the vagina and is killed," says Catherine Weiss, head of the Reproductive Freedom Project of the American Civil Liberties Union. "That's what an abortion is."

So far, proponents of legal abortion in Wisconsin have lost in court. But they gained a great deal of national support when doctors like Christensen temporarily stopped performing abortions. Pro-choice activists as far away as Tallahassee, Florida, held a news conference calling attention to what happened in Wisconsin in the hope of adding urgency to their quest to overturn a similar Florida law, which has yet to take effect.

"Shock waves went through this country when abortion clinics didn't open and provide services," says Planned Parenthood's Korsmo. "It was an eye-opener."

Gloria Feldt, president of the Planned Parenthood Federation of America, says the Wisconsin law proves that the anti-abortion forces "will do anything to avoid debate over whether abortion should be legal. Instead, they're just trying to figure out how to take access away. But the very draconian nature of the punishment has brought to the public attention just how wrongheaded these laws are."

Armacost of Wisconsin Right to Life calls the clinic shutdown a ruse. "They claimed all abortions would be affected and that they'd be swept up and taken to prison," she says. "But if they were so con-



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cerned, they would not be back in business now."

Abortion doctors in Wisconsin did go on strike in part to dramatize their situation. But they also are genuinely worried about this new government incursion into their practice. And they know there is the possibility that performing a certain, common procedure—even early in a pregnancy—can now land them in jail. Most of them are back at work, however, having received written assurances from the district attorney in their area that they will not be prosecuted for first-trimester abortions.

But abortions after the first trimester, and any dilation and extraction procedures, may expose them to jeopardy. Already, the legal battles have been costly. The ACLU's Weiss estimates that fighting the "partial-birth" bills has drained about one-third of her $1 million budget for the past year. "Absorbing this onslaught has been very difficult, and that's the way the anti-choice people want it," she says. "They know very well these bills are unconstitutional, but they keep [the issue] alive because it's good P.R. in the press to focus on a gruesome procedure."

The Wisconsin case returns to Judge Shabaz's court for an injunction hearing in June. If he rules the ban constitutional, Planned Parenthood will appeal to the full Seventh Circuit Court of Appeals. If it loses there, it would likely go to the U.S. Supreme Court, which could uphold the ban, toss it out, or choose not to hear the case at all, which would mean that the ban would stick.

Pro-choice advocates still think their side will win in the higher courts. In *Roe v. Wade*, the Supreme Court held that states may not regulate first-trimester abortions, which the Wisconsin law, with its broad language, appears to do.

But until the courts make their final determination, doctors who practice abortion will be operating in quicksand. "The evil of this law is that you're going to force doctors to start conducting their medical practice with a criminal lawyer in the background," says Roger Evans, the national Planned Parenthood attorney who is fighting the Wisconsin law. "Now doctors will be making decisions in the middle of medical procedures to protect themselves from the reach of this law."

That's already happening at the Madison Abortion Clinic. Christensen got the D.A.'s approval to do abortions up to the fifteenth menstrual week. But as a doctor at a referral clinic, he usually takes patients through the twenty-fourth week. For now, he has made a decision to continue all abortions, but he won't do them the same way he used to.

"I'll have to alter my surgical technique—and at times that will be a less-than-optimal medical procedure," says Christensen. "I'm appalled that this is how clinical decisions are being made, but I think this is just a harbinger of things to come."■

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MESSAGE

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Gender bias is rampant in the existing health care delivery system. Nearly 38 million Americans lack health coverage, with women particularly vulnerable to losing insurance because their ability to obtain coverage is often dependent upon employment, income, and/or marital status. More women than men fail to receive routine, preventive services, and when ill, are less likely to seek treatment due to cost or inadequate insurance. Finally, in the provision of care, women's health and their special care needs have often been ignored by the medical profession.

Three key principles of the Administration's American Health Security Act (AHSA) -- universal coverage, a guaranteed benefits package, and an emphasis on preventive care -- will significantly improve women's access to health care. But these principles alone will not guarantee health care free of gender bias unless a full range of care appropriate to women's special needs are covered, affordable, available, and offered in a manner that guarantees confidentiality and non-discrimination.

Universal coverage

For the 12 million women who lack health coverage and the millions more who are underinsured, a health care reform plan ensuring universal coverage is of primary importance. Therefore, women have a great stake in how the AHSA defines eligibility for guaranteed coverage and how financial assistance is allocated.

The AHSA requires employers to subsidize coverage for employees and their families. For full-time workers, 80 percent of the average premium will be provided by

their employer. Those working 40-120 hours will receive a reduced employer subsidy, while those working under 40 hours per month will have no employer share. The AHSA's employer-based program may disadvantage women for several reasons. Women are more likely than men to be part-time, temporary, or seasonal employees, making them less likely to be eligible for employer subsidies. Moreover, the recent "nanny-gate" concerns exacerbate pressures to define domestic workers and other traditionally female-dominated professions as self-employed or independent contractors, which would alleviate the employer requirement. The AHSA will provide government subsidies for insurance coverage for low-income persons, including those who do not receive employer subsidies. The Medicaid program, which currently provides reimbursement for health care services for AFDC recipients, the majority of whom are women, will be discontinued after 1998. By that time, Medicaid recipients must be enrolled in health care plans and entitled to the same government subsidies as other low-income persons.

AHSA's definitions of "family," "spouse," and "child" may dramatically affect which groups of individuals receive coverage as a family and the amount of financial assistance provided, as well as the health insurance available to families not fitting the established definitions. In large part, definitions of both "spouse" and "child" are left to the determination of state laws, which vary considerably and may work to the disadvantage of households headed by women. In addition, the National Health Board may issue rules for families where members are not residing in the same geographic

area, where children are not residing with their parents, and where parents have recently separated or divorced. Because women are more dependent upon spousal insurance and are more likely to retain custody of children during a separation, these yet-to-be-written rules may have an adverse effect on women.

Benefit package and focus on prevention

Some of the greatest debate in Congress over health care reform will focus on the contents of the AHSA's guaranteed package of benefits. Among the services most likely to be targeted for removal are women's reproductive health services, including mammography, pap smears, and pelvic exams; testing for and prevention of sexually transmitted diseases and unwanted pregnancy; and abortion. Even the services currently included, however, do not provide the comprehensive reproductive health care that is necessary to adequately address women's health care needs.

Although the AHSA ensures certain clinical preventive services without cost-sharing requirements, these services are provided only for certain age groups and according to periodicity schedules, which represent outmoded and potentially health-threatening assumptions about when women are sexually active. For example, chlamydia and gonorrhea testing is available only for women between the ages of 13 to 49 who are at risk for "fertility related infectious diseases." Since sexually active women over age 49 are no longer "fertile," they do not qualify for this testing. At the same time, other kinds of sexually transmitted diseases -- notably syphilis, herpes,

pelvic inflammatory disease, and the HIV virus -- are not specifically covered in this formulation of preventive care. Meanwhile, although important tests that screen for breast and cervical cancers are included, the singling out of these services could ironically result in unequal treatment for women. Those women who seek pap smears, mammograms, and/or pelvic exams that do not correspond to the age and periodicity limits could, arguably, be covered for such care as part of the "services of health professionals" and/or "outpatient laboratory, radiology, and diagnostic services" in the same way that men would be covered for prostate and other cancer screening. But a narrow reading of the complicated and confusing language might allow a health plan to claim that coverage for those women-specific diagnostic services is limited to the scope of the preventive services, leaving women with less coverage than men.

Family planning services -- which are critical to preventing both sexually transmitted diseases and unwanted pregnancies -- are listed separately in the benefits package and require cost-sharing. The fact that family planning services do not fall within the clinical preventive services or "services of health professionals" reflects the biased assumption that these services are different than the more general categories of medically necessary or appropriate care and leaves them vulnerable to removal. While the plan includes broad coverage for prescription drugs and biologicals, which by any liberal reading should include oral contraceptives prescribed by a health professional, current insurance plans with similar language often deny coverage unless contraceptives are specifically included. Since contraceptive devices are specified, the

addition of clear language for contraceptive drugs would best ensure their availability. Unfortunately, neither coverage for prescription drugs and biologicals, nor coverage for family planning services, includes over-the-counter contraceptives, some of which -- like condoms and foam -- are critical to preventing HIV infection, other sexually transmitted diseases, and unwanted pregnancy.

Although not explicitly detailed, the Clinton Administration has assured the pro-choice community that "services for pregnant women" include abortion -- the most common surgical procedure in the United States. But in contrast to the term "pregnancy-related services," contained in an earlier version of the AHSA, which had a clear medical definition, this intentionally vague term may be open to adverse interpretations that exclude abortion or other reproductive care. The vagueness concerns will most likely be vitiated as abortion opponents are expected to try to explicitly exclude abortion coverage from the AHSA or allow states to exclude these critical health services. Should those efforts succeed, the national health plan itself would reflect a bias against the provision of health services needed exclusively by women.

Moreover, rather than guaranteeing coverage for all medical care falling within the broad categories listed in the benefits package, the AHSA excludes an item or service that is not medically necessary or appropriate and gives the National Health Board wide latitude in determining the kinds of medical procedures that may be excluded under this standard. As a result, significant litigation may be necessary to

determine whether particular health services are fully covered within the benefits package. Again, where there is an organized opposition to providing a full range of services, such as abortion and contraception, this exclusionary language may operate to the disadvantage of women. For example, despite a guarantee of coverage for all medically necessary services under the federal Medicaid program, Congress and some states have limited the availability of abortion by narrowly defining medical necessity.

Other women's health concerns

Without efforts to improve access to services, ensure confidentiality, and aggressively prohibit sex discrimination, the AHSA may fail to provide women with the health care they need.

Access to women-specific services

Women currently face a shortage of health professionals who provide comprehensive services, including reproductive health care. Particularly acute is the scarcity of obstetricians and gynecologists and physicians willing to perform abortion services: _____ percent of all counties in the nation lack an ob/gyn, while 83 percent of counties lack a physician willing to perform an abortion. Moreover, as non-sectarian hospitals join with some religious facilities to form HMO's or provider networks, they are refusing to provide abortion and birth control services. For example, when Cincinnati Jewish Hospital joined forces with local Catholic institutions

to operate an HMO, the Catholic hospitals demanded, as a condition of the joint venture, an end to the Jewish hospital's abortion services.

Numerous state restrictions, including mandatory delays and parental involvement requirements, make it more difficult for women to obtain reproductive health services. Both the shortage of providers and the state-imposed impediments to receiving timely care are already forcing women to travel long distances and delay receipt of appropriate care. ASHA's requirement of pre-approval for services by a "gatekeeper" will only exacerbate these problems. Low-income women who must participate in an HMO "gatekeeper" plan in order to obtain financial assistance will be particularly harmed.

Compounding these problems, a "conscience clause" in the AHSA provides that a health professional or facility may not be required to provide a service if the professional or facility objects to doing so on religious or moral grounds. There is nothing objectionable about affording individual medical practitioners the right to refuse to provide care to which they have moral or religious objections. Health plans and hospitals that receive public monies and offer their services to avoid their duty to provide these essential services. Significantly, the AHSA makes no provision should all the health professionals and facilities within a particular health plan or alliance refuse, on religious or moral grounds, to provide a covered service. Indeed, the AHSA's "business necessity" defense may allow the plan to exclude the service outright. Given the widespread unavailability of abortion, the AHSA must explicitly

require that physicians and hospitals exercising their rights under the conscience clause or otherwise refusing to offer care provide women with appropriate referrals and that the health plans cover additional costs women incur, including co-payments or transportation, to obtain this care.

By establishing a program to encourage medical students to specialize in primary care, including obstetrics and gynecology, the AHSA attempts to alleviate the current shortage of primary care providers. In addition, the AHSA encourages the removal of licensing and regulatory barriers that prevent advanced practice nurses and physician assistants from providing a variety of appropriate services, including reproductive health care. While these new programs may alleviate some of the provider shortage affecting women's health care, it is not clear how effective they will be in reducing the shortage of reproductive health providers, who are often discouraged from offering these services by ongoing violence and harassment and prohibitive malpractice insurance rates.

Further, the AHSA will eliminate or fold into block grants a number of specialized programs and funding schemes designed to provide services to underserved populations, often primarily women (Title X family planning funds, preferential 90 percent federal reimbursement for contraceptives under Medicaid, the expanded Medicaid reimbursement program for pregnant women with incomes above the poverty level, funding for community health centers, and Ryan White AIDS Program monies, to name a few). But state control of these grants is likely to

undermine the effectiveness and scope of these programs and to provide disparate treatment from state to state, particularly for "controversial" services.

Privacy and confidentiality

While assurances of privacy and confidentiality are critical to any person, these concerns are especially important to women seeking reproductive health care. Although the plan provides some protection against unauthorized use of health information, many of the details of this privacy mandate are not included within the AHSA. The reliance on an employment-based and family-based model of coverage raises serious questions about whether women will be able to obtain sensitive services -- including family planning, pregnancy testing, diagnosis and treatment of sexually transmitted diseases, and abortion services -- without notice to either an employer or a family member. The experience of reproductive health care providers already shows that, even when women have insurance coverage, they avoid utilizing that coverage for fear of disclosure.

Non-discrimination

The AHSA contains a number of specific prohibitions against discrimination. As with other federal anti-discrimination statutes, however, there is likely to be significant litigation before the full scope of these provisions is known. Both a state operating a single-payer system and a regional alliance are specifically prohibited from discriminating on the basis of sex when contracting with health plans. Similarly, no health plan may adopt policies that have the effect of discriminating against an

individual on the basis of sex nor discriminate against women when selecting providers or establishing the terms or conditions of membership in a provider network. However, when a state establishes boundaries for regional alliances, the AHSA prohibits discrimination on the basis of race, age, language, religion, national origin, socio-economic status, disability, or perceived health status; there is no similar prohibition on sex-based discrimination. Despite efforts to prohibit plans from engaging in any practice that has the effect of attracting or limiting enrollees based on personal characteristics, the itemization of such personal characteristics does not include sex and is therefore susceptible to a reading that excludes it.

Except in the case of intentional discrimination, the anti-discrimination provisions in the AHSA are not violated where an action is required by "business necessity." This broad business necessity defense may have a great impact on claims of gender discrimination. Women's claims of discrimination frequently are based on a theory of disparate treatment, rather than intentional discrimination. Because health and hospital administrators, like employers, know that there may be legal ramifications if they overtly exclude women, the discriminatory actions are often more subtle. Further, it may be more costly to provide the full range of gender-specific health care for women than to provide a comparable level of gender-specific services to men, thus providing a basic for exclusion due to business necessity.

In the AHSA, sex-based discrimination is not specifically defined to include discrimination based on one's childbearing choices. Several Supreme Court cases

have specifically held that discrimination based on pregnancy or abortion is not sex-based discrimination. In response, Congress passed the Pregnancy Discrimination Act, an amendment to Title VII of the Civil Rights Act, to clarify that pregnancy-based discrimination is included within the prohibitions on sex-based discrimination (although abortion discrimination was explicitly excluded). When recently interpreting another civil rights statute, the Supreme Court held that discrimination against women who choose abortion is not sex-based discrimination. Thus, clarifying language, which defines sex-based discrimination to specifically include pregnancy- and abortion-related discrimination, would be the most prudent approach for ensuring that women are adequately protected by the AHSA.

Conclusion

As is evidenced by many of the concerns raised above, it is the details of the final product, rather than the broad approach, that may make the most significant difference for women's health care needs. Given the comprehensive scope of the AHSA, and the fact that the final plan is likely to be an amalgamation of the various proposals pending in Congress, efforts to prevent gender bias must continue throughout the reform process as specific legislative language is considered and adopted.

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Reproductive Freedom news

FROM THE CENTER FOR REPRODUCTIVE LAW & POLICY

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MAR 17 1995

MEMORANDUM

TO: Interested Parties
FROM: Cory L. Richards
Vice President for Public Policy
DATE: March 1995
SUBJECT: New AGI *Issues in Brief*

I am pleased to enclose the newest installment in The Alan Guttmacher Institute's *Issues in Brief* series, **"The Cost Implications of Including Abortion Coverage Under Medicaid."**

This policy paper examines the implications--both to individual women and to the federal and state governments--of restoring Medicaid coverage of abortions. Using current Medicaid eligibility ceilings, AFDC benefits and abortion charges for each state, it shows how little income women must have to qualify for Medicaid and how difficult it is for them to pay for an abortion in the absence of Medicaid coverage. It also includes estimates of federal and state expenditures and savings for each state if the Hyde amendment were eliminated to demonstrate that withholding Medicaid coverage for abortion in an attempt to influence poor pregnant women to have a baby--even when they are convinced they cannot afford to raise the child and wish to terminate the pregnancy--is far more costly than letting women make up their own minds about how to deal with an unintended pregnancy and making that choice possible.

I hope you find this information useful in your work. If we can provide further assistance in any way, please feel free to contact the Institute's Washington Office.

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The Cost Implications of Including Abortion Coverage Under Medicaid

Funded and administered jointly by the federal government and the states, Medicaid reimburses physicians and other health professionals for the care they provide to individuals whose combined incomes and resources are deemed by law to be "insufficient to meet the cost of necessary medical services." Income eligibility ceilings are so low, however, that the program covers fewer than half (47%) of those who live in poverty. Nearly three-quarters (71%) of Medicaid recipients are children and adults on Aid to Families with Dependent Children (AFDC), the cash assistance program for needy families commonly referred to as welfare. Yet, the bulk of Medicaid expenditures (69%) go for services for the elderly, blind and disabled, who account for only 27% of all Medicaid recipients; a quarter of all Medicaid expenditures are for nursing home services.

Between 1967 -- when states first began to liberalize their restrictive abortion laws -- and 1977, federal Medicaid coverage of abortions was available without restriction nationwide. Each year since then, however, Congress has enacted one or another version of the so-called Hyde amendment, which severely restricts funding; between FY 1981 and FY 1993, for example, federal coverage was available only if a woman's life would be endangered if her pregnancy were carried to term. In FY 1994, Congress expanded coverage slightly to include pregnancies that result from rape and incest.

In the wake of the cutoff of federal funds, the majority of states adopted policies similar to the federal standard. However, 17 states and the District of Columbia currently use their own funds to provide abortions for Medicaid recipients. Nine of these states opted to pay for abortions; courts in the others have ruled that restricting Medicaid coverage violated poor women's equal protection rights under their respective state constitutions.

This Issues in Brief examines the cost implications -- both to individual women and to the federal and state governments -- of restoring Medicaid coverage of abortions. It shows how little income women must have to qualify for Medicaid and how their income is "insufficient to meet the cost" of an abortion. It demonstrates that withholding Medicaid coverage of abortions in an attempt to influence poor women who become pregnant to have the baby -- even when they are convinced they cannot afford to raise the child and wish to terminate the pregnancy -- is far more costly than letting women make up their own minds about how to deal with an unintended pregnancy and making that choice possible.

Cost Implications for Women

Medicaid eligibility. By law, Medicaid coverage is automatically extended to AFDC recipients. In addition, states have the option to extend Medicaid coverage to the "medically needy" -- individuals and families whose incomes are slightly higher than the AFDC eligibility ceiling or who otherwise do not meet the requirements of AFDC.

Each state sets its own income eligibility levels for AFDC and medically needy status; levels vary widely from state to state. Nationwide, the average income ceiling for a single-parent family of three to qualify for Medicaid coverage (including both AFDC recipients and the medically needy) is $6,004 -- only 49% of the 1994 federal poverty level of $12,320 for a family that size; the ceiling ranges from 16% of poverty in Alabama to 91% in California (columns 1 and 2).

Income. About two-thirds of reproductive-age women who qualify for Medicaid do so by virtue of their status as AFDC recipients. The AFDC payment constitutes most of the income of these women and their families, because federal law prohibits recipients