



PROPOSED ACTION
MEMORANDUM

Modernizing Hyde Amendment Regulations

Misc. Agencies
April 2022

I. Summary

The Hyde Amendment prevents federal programs from paying for abortion services except when terminating a pregnancy that results from rape or incest or that is necessary to save the life of the mother (“Hyde exceptions”). As a result, millions of federal employees, Medicaid beneficiaries, military personnel and veterans, incarcerated people, Native Americans, and Peace Corps volunteers, among others, may be unable to access affordable abortion services. The Hyde Amendment is especially burdensome for low-income women¹ with public coverage who may not be able to obtain an abortion without public funding.

To help ensure meaningful coverage of abortions that fall under the Hyde exceptions, federal agencies could modernize existing regulations that implement the Hyde Amendment. Many current federal rules are inconsistent with the text of the Hyde Amendment, unnecessarily burdensome, and limit access to qualifying abortions. In particular, affected agencies should revise their rules on the Hyde Amendment to (1) ensure coverage for the full scope of Hyde exceptions; (2) confirm that life-threatening conditions, such as ectopic pregnancies, qualify as endangering the life of the mother; and (3) adopt standardized, reasonable reporting and certification requirements (and waivers of these requirements).

II. Justification

Federal programs finance health coverage and health care for millions of women, making public funding central to maternal health. Medicaid, for instance, is the nation’s largest source of coverage and covered a record-high 78.9 million people as of November 2021, including 43.8 million adults.² Other federal programs—such as the Indian Health Service (IHS), the Children’s Health Insurance Program (CHIP), the Federal Employee Health Benefits Program, TRICARE, federal prisons, and the Peace Corps—also provide coverage and care for millions of employees, military personnel and their families, and volunteers, among others.

The Hyde Amendment has dramatically limited the coverage of abortion under these programs. Although abortion is an essential health service, an estimated 7.8 million women—half of whom are women of color—cannot access this care due to the Hyde Amendment.³ Without coverage, abortion is very costly. Out-of-pocket costs vary by method, location, facility, gestational age, and travel costs, and these costs have generally increased over time.⁴ Median patient charges for medication abortion increased from \$495 in 2017 to \$560 in 2020.⁵ Costs for a first-trimester procedural abortion increased by \$100, from \$475 in 2017 to \$575 in 2020 while the cost of a second-trimester abortion decreased by \$40 during this period.⁶ When one-quarter of Americans cannot afford a \$400 emergency,⁷ many simply cannot afford the cost of an abortion.

¹ Cisgender women are not the only individuals who can become pregnant and may need abortion services. These recommendations extend equally to transgender men, nonbinary people, and gender nonconforming people who may need an abortion.

² Centers for Medicare and Medicaid Services, [October and November 2021 Medicaid and CHIP Enrollment Trends Snapshot](#) (last accessed Apr. 22, 2022).

³ Guttmacher Institute, [The Hyde Amendment: A Discriminatory Ban on Insurance Coverage of Abortion](#) (May 2021).

⁴ Alina Salganicoff et al., [The Hyde Amendment and Coverage for Abortion Services](#), Kaiser Family Foundation (Mar. 2021).

⁵ Ushma D. Upadhyay et al., “Trends in Self-Pay Charges and Insurance Acceptance for Abortion in the United States, 2017-20,” *Health Affairs* 41(4) (2022).

⁶ *Id.*

⁷ Federal Reserve, [Report on the Economic Well-Being of U.S. Households in 2018](#) (May 2019).

These costs have an impact. One study found that 29% of Medicaid-eligible pregnant women in Louisiana would have opted for an abortion instead of birth if the procedure were covered by Medicaid.⁸ Louisiana is among the 34 states and the District of Columbia with extremely limited abortion coverage due to the Hyde amendment.⁹

High costs of abortion are disproportionately borne by low-income women, young women, and women of color.¹⁰ By denying coverage for medically necessary care, the Hyde Amendment not only deprives low-income women of their right to bodily autonomy but also entrenches them in poverty by forcing them to pay the out-of-pocket costs associated with an abortion or carry an unwanted pregnancy to term, straining their already limited means.

While the Hyde Amendment itself is restrictive, current regulations make it challenging for exempted abortions to be covered. As discussed below, current regulations are outdated and impose more stringent restrictions than the current Hyde Amendment. Some do not reflect current Hyde exceptions for rape or incest while others impose restrictive certification and reporting requirements. As one data point on the potential impact, a 2002 analysis found that only 25 abortions were reportedly performed in the IHS system since 1976.¹¹

III. Current State

Congress has adopted some version of the Hyde Amendment since 1976. Named after its sponsor, Rep. Henry J. Hyde, Congress attaches this annual rider to appropriations bills for various federal agencies. The first version of the Hyde Amendment, adopted in the wake of *Roe v. Wade*, restricted federal Medicaid funds from being used for abortion, except where the life of the mother would be endangered if the fetus were carried to term.¹² Congress has continued to enact some form of this rider for the past 46 years and applied the Hyde Amendment to most federal programs.¹³

Most recently, Congress included Hyde Amendment riders in the 2022 Consolidated Appropriations Act, which was signed into law on March 15, 2022.¹⁴ In general, these provisions state that appropriated funds are not “available to pay for an abortion, except where the life of the mother would be endangered if the fetus were carried to term, or in the case of rape or incest.”¹⁵ This restriction applies to the Department of Justice, the Department of State, the Office of Personnel Management, and the District of Columbia. The Department of Defense is also prohibited from using appropriated funds to perform abortions except when the life of the mother would be endangered or in case of rape or incest.¹⁶

⁸ Salganicoff et al., *supra* note 4.

⁹ *Id.*

¹⁰ *Id.*

¹¹ See Allison Herrera, “Indigenous Women Face Extra Barriers When It Comes to Reproductive Rights,” *High Country News* (Feb. 14, 2020).

¹² Departments of Labor and Health, Education, and Welfare Appropriations Act, 1977, Pub. L. No. 94-439, 90 Stat. 1418, 1434 § 209 (1976).

¹³ Hyde exceptions have varied over the years, with some riders not exempting rape or incest. Since 1994, however, Congress has allowed Hyde exceptions in three instances: endangerment of the life of the mother and for rape or incest.

¹⁴ Appropriations Act, 2022 (H.R. 2471), Pub. L. No. 117-103, 136 Stat. 49 (2022).

¹⁵ *Id.* at Div. B, tit. 2 § 202.

¹⁶ 10 U.S.C. § 1093.

Hyde restrictions are more detailed for the Department of Health and Human Services (“HHS”), the Department of Labor, and the Department of Education. Appropriated funds for those agencies cannot be used for an abortion “(1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.”¹⁷

Litigation Over The Hyde Amendment

The Supreme Court has upheld the Hyde Amendment and implementing regulations against various constitutional challenges. In *Harris v. McRae*, the Court found that the Hyde Amendment did not implicate the fundamental right to an abortion recognized in *Roe*, because it did not place an obstacle in the path of a woman who chose to terminate her pregnancy.¹⁸ The Hyde Amendment was rationally related to the governmental interest of “protecting the potential life of the fetus.”¹⁹ In *Britell v. United States*, the Federal Circuit upheld the Department of Defense’s refusal to cover an abortion of a fetus diagnosed with anencephaly, a lethal fetal anomaly.²⁰ Even though the fetus did not have potential life, the Federal Circuit held that the government has a legitimate “unqualified interest in preserving human life regardless of the physical or mental condition.”²¹ Only Congress could make exceptions for federal funding of an anencephalic fetus or where the health of the mother was at risk. Because the statute did not include those exceptions, the court concluded that those abortions could not be covered.

Agency Rules And Guidance To Implement The Hyde Amendment

Federal agencies have adopted regulations and guidance to implement the Hyde Amendment. But many of these policies have remained the same even as the language of the Hyde Amendment has changed over time. As a result, current rules are outdated, inconsistent, and limit coverage for abortions that should be eligible for federal funding even under the Hyde Amendment.

As shown in the chart below, regulations that implement the Hyde Amendment vary dramatically, even within the same agency. For instance, current regulations for Medicaid and IHS²² (as well as TRICARE) do not include exemptions when pregnancy results from rape or incest while regulations for CHIP and HHS programs and

¹⁷ Pub. L. No. 117-103 at Div. H, tit. 5 § 507. This language has remained substantially unchanged since 1997 when Congress narrowed its prior Hyde Amendment language. Under the pre-1997 language, Congress statutorily required women to report rape or incest to a law enforcement agency—or obtain certifications from two physicians that she could sustain “severe and long-lasting physical health damage” if the pregnancy were carried to term. *See* 90 Stat. 1418, 1434 § 209.

¹⁸ 448 U.S. 297(1980). Three years before the decision in *McRae*, the Court had upheld the Hyde Amendment’s restriction of nontherapeutic abortions under the Medicaid program. *See* *Maier v. Roe*, 432 U.S. 464 (1977).

¹⁹ *McRae*, 448 U.S. at 324. The Court noted that although *Roe* emphasized that the health of the mother (both physical and psychological) was one of the interests protected by the Fourteenth Amendment, that protection did not carry with it an “entitlement to the financial resources to avail herself of the full range of protected choices.” *Id.* at 316. The majority rejected arguments made by Justice Marshall in dissent that “for women eligible for Medicaid—poor women—denial of a Medicaid-funded abortion is equivalent to denial of legal abortion altogether.” *Id.* at 338.

²⁰ 372 F.3d 1370 (Fed. Cir. 2004).

²¹ *Id.* at 1383.

²² Although appropriations for IHS are made under separate appropriations for the Department of Interior (which does not have a parallel Hyde Amendment restriction), the IHS is subject to HHS’s Hyde Amendment restrictions under 25 U.S.C. § 1676.

services do. Most, but not all, rules specify that publicly funded coverage is available for an ectopic pregnancy. Some rules, which are relics of older versions of the Hyde Amendment, impose burdensome certification and reporting requirements, especially on victims of rape and incest. To obtain coverage from an HHS program or service, for instance, a woman must file a report with law enforcement within 60 days of an assault and then obtain and submit signed documentation as proof of their assault.

Summary of Existing Key Regulations Implementing the Hyde Amendment

Program	Source	Life of Mother is Endangered				Victim of Rape or Incest	
		Coverage is Available	Written Physician Certification	Reporting Standards	Ectopic Pregnancy	Coverage is Available	Reporting Standards
Medicaid	42 CFR § 441.200 et seq.	☑	☑	☑ ^{a,b}	☑	☒	
CHIP	42 CFR § 457.475	☑			☒	☑	
HHS Programs and Services	42 CFR § 50.301 et seq.	☑	☑	☑ ^a	☑	☑	☑ ^c
IHS	42 CFR § 136a.51 et seq.	☑	☑	☑ ^b	☑	☒ ^d	
Federal Prisons	28 CFR § 551.23, Manual ²³	☑			☒	☑	
TRICARE	32 CFR §§ 199.2, .4	☑ ^e	☑		☑	☒ ^f	

^a Physician certification must be received by the relevant authority before payment.

^b The relevant authority must maintain copies of the certification and documentation for 3 years.

^c The patient must obtain signed documentation from a law enforcement agency or public health service within 60 days of the incident. The signed documentation must (1) state that the patient reported to have been a victim of rape or incest; (2) include the date of the incident and report; and (3) include the name and address of the victim and the name and address of the person making the report (if different from the victim).

^d A memorandum from 1996 lists rape and incest as allowable exceptions for abortion services, but these exceptions are not reflected in the regulations or general manual. To obtain coverage in the event of rape or incest, the memorandum requires women to obtain signed documentation from a law enforcement agency or public health service within 60 days of the incident.

^e The regulation states that abortions performed for suspected or confirmed fetal abnormality (e.g., anencephalic) or for mental health reasons (e.g., threatened suicide) do not qualify as exceptions and thus are not authorized for payment.

^f The TRICARE manual states that coverage may be available when a pregnancy is the result of an act of rape or incest, but the regulations are limited to only when the life of the mother is endangered.

²³ Federal Bureau of Prisons, [Female Offender Manual](#), No. 5200.07, U.S. Department of Justice, at 16-17 (May 2021).

Beyond regulations, some agencies have issued interpretive guidance to implement the Hyde Amendment.²⁴ After Congress eliminated an exception for rape and incest from the Hyde Amendment in 1981, HHS revised its Hyde rules to remove a provision that allowed federal funds to be used for abortion in cases of rape or incest.²⁵ Congress readopted an exception for rape and incest for fiscal year 1994, leading HHS to issue guidance noting that “all abortions covered by the Hyde Amendment, including those abortions related to rape or incest, [we]re medically necessary services and [we]re required to be provided by states participating in the Medicaid program.”²⁶ The guidance also said states could impose “reasonable” reporting or documentation requirements so long as those requirements did not “serve to deny or impede coverage for abortions.”²⁷ In particular, HHS directed states to waive reporting requirements if a treating physician certified that the patient was unable to comply with the reporting requirements for “physical or psychological reasons.”²⁸ This waiver of reporting requirements was upheld by the Third Circuit in 1995 as a reasonable interpretation of the Hyde Amendment.²⁹

Although the Hyde Amendment and its implementing rules and guidance can preempt state laws that attempt to limit reimbursement under federal programs,³⁰ enforcement has been lax even in the face of severe state restrictions. In 2019, the U.S. Government Accountability Office (“GAO”) noted that HHS had taken no action against South Dakota’s Medicaid program, which does not cover abortion in the cases of rape or incest.³¹ Further, 14 state Medicaid programs did not cover mifepristone, an FDA-approved drug used to terminate a pregnancy, meaning women who qualified for abortion coverage under exceptions in those states must obtain a surgical abortion in the cases of life endangerment, rape, or incest.³² Still other states impose reporting and provider certification requirements, prior authorization requirements, or certification of counseling requirements.³³

IV. Proposed Actions

Current federal Hyde regulations are unnecessarily stringent and burdensome, leaving women without access to affordable abortion services even in circumstances that qualify as Hyde exceptions. To ensure meaningful access, affected agencies should issue revised rules that reflect the current text of the Hyde Amendment and eliminate unnecessary barriers to covered abortions. At a minimum, all regulations should:

- Ensure coverage for the full scope of Hyde exceptions;
- Confirm that life-threatening conditions, such as ectopic pregnancies, qualify as endangering the life of the mother; and

²⁴ See, e.g., Sally K. Richardson, Letter to State Medicaid Directors, Center for Medicaid and State Operations (Mar. 25, 1994); Sally K. Richardson, Letter to State Medicaid Directors, Center for Medicaid and State Operations (Dec. 28, 1993).

²⁵ 52 Fed. Reg. 47926, 47931-32 (Dec. 17, 1987).

²⁶ See Sally K. Richardson, [Letter to State Medicaid Directors](#), Center for Medicaid and State Operations (Feb. 12, 1998) (describing the guidance from 1993).

²⁷ *Id.*

²⁸ *Id.*

²⁹ Elizabeth Blackwell Health Ctr. for Women v. Knoll, 61 F.3d 170, 182 (3d Cir. 1995) *cert. denied* 516 U.S. 1093 (1996).

³⁰ *Id.*; see also *Hern v. Beye*, 57 F.3d 906 (10th Cir. 1995) (holding that Colorado’s constitutional amendment that failed to exempt abortions for incest and rape violated the Medicaid statute and therefore preempted).

³¹ U.S. Government Accountability Office, [CMS Action Needed to Ensure Compliance with Abortion Coverage Requirements](#) (Jan. 2019).

³² *Id.*

³³ *Id.*

- Adopt standardized, reasonable reporting and certification requirements (and waivers of these requirements).

Where a current agency rule does not reflect the full scope of Hyde exceptions, agency action is clearly appropriate to conform federal rules to the text of the Hyde Amendment. By clarifying the scope of covered abortions, agencies will fulfill Congress’s clearly stated goal that federal funding should be available for certain abortions. In the absence of clarification, existing rules prevent women from obtaining coverage for an abortion that otherwise qualifies as a Hyde exception. Further changes—such as broadening the list of conditions that qualify as endangering the life of the mother or modernizing certification and reporting requirements—can be justified as reasonable interpretations of the Hyde Amendment exceptions that are entitled to *Chevron* deference.

First, each agency should explicitly state that federal funds are available to cover abortions when the life of the mother is endangered or when the pregnancy is the result of rape or incest. Regulations that do not offer the full scope of coverage are inconsistent with the text of the Hyde Amendment and unduly restrict access to affordable abortion services.

Second, each agency should explicitly confirm that life-threatening conditions, including but not necessarily limited to ectopic pregnancies, qualify as endangering the life of the mother for purposes of the Hyde Amendment. The inclusion of ectopic pregnancy is explicit in some, but not all, current rules and should be made clear across federal agencies. Agencies could also clarify that other physical health conditions associated with a high-risk pregnancy—such as preeclampsia, diabetes, cancer, heart disease, high blood pressure, asthma, epilepsy, and HIV/AIDS—can endanger the life of the mother.³⁴ Critics will argue that a high-risk pregnancy alone does not endanger the life of the mother and should not be eligible for federal funding. But these concerns could be neutralized by the fact that certification requirements would remain in place, meaning a physician would still have to certify, in writing, that a mother’s life is in danger.

Third, each agency should adopt standardized, reasonable reporting and certification requirements. Agencies should, for instance, develop a standardized form for physicians to certify that abortion is necessary to protect the life of the mother. These situations are, by definition, emergencies, and standardized documentation requirements could help minimize delays in treatment, promote patient privacy, and better ensure that coverage is available under a Hyde exception.

Further, agencies should eliminate burdensome reporting requirements for victims of rape or incest. Rape and incest are vastly underreported crimes.³⁵ Many women, for a range of reasons, do not report these incidents to law enforcement or other authorities at all—or may not do so within 60 days. Stringent non-statutory reporting requirements thwart Congress’s goal of ensuring that victims of these crimes have financial support to terminate a pregnancy. Instead of existing reporting standards, agencies could consider self-attestation or physician certification. These approaches could be especially helpful for low-income women “who may be least likely to be aware that a rapid report to the authorities is indispensable for them to be able to obtain an abortion.”³⁶ At a minimum, agencies should waive reporting requirements for incest or rape, similar to the standard included in HHS guidance from 1993.

³⁴ See National Institutes of Health, [High-Risk Pregnancy](#) (last accessed Apr. 22, 2022).

³⁵ Since 2015, between 70 and 80- percent of rapes and sexual assaults went unreported. Department of Justice, [Criminal Victimization, 2020](#), NCJ 301775 (Oct. 2021); U.S. Department of Justice, [Criminal Victimization, 2016, Revised](#), NCJ 252121 (Oct. 2018).

³⁶ *McRae*, 448 U.S. at 340 (Marshall, J., dissenting).

Process To Revise Or Adopt Rules To Implement The Hyde Amendment

Federal agencies have used a range of procedures to issue and revise rules to implement the Hyde Amendment. HHS and the Department of Justice, for instance, have bypassed notice and comment rulemaking procedures altogether, explaining that immediate changes are needed³⁷ and invoking good cause exceptions.³⁸ In other cases, HHS used full notice and comment rulemaking procedures to implement the Hyde Amendment, including in issuing a rule that extended the Hyde Amendment to IHS.³⁹ Still in other cases, HHS has included Hyde-related provisions in broader omnibus rules that have been subject to notice and comment rulemaking procedures.⁴⁰

The recommended process to revise Hyde rules will vary based on the extent of changes that an agency wants to make. If an agency is simply conforming its Hyde regulations to the exceptions included in the current Hyde Amendment, this memorandum recommends that the agency do so in a final rule without notice and comment rulemaking. As agencies have cited in the past, there is good cause to waive notice and comment requirements under Section 553(b)(B).⁴¹ If an agency wants to adopt *broader* changes—such as modernizing reporting requirements for victims of rape and incest— this memorandum recommends complying with notice and comment rulemaking procedures.

³⁷ See, e.g., 44 Fed. Reg. 61598, 61598 (Oct. 26, 1979) (waiving proposed rulemaking and instead issuing a final rule because the appropriations rider became effective on October 1, 1979 and immediate rulemaking was “necessary to provide immediate direction to States as to which abortions may be funded with appropriations for FY 80”).

³⁸ See, e.g., 59 Fed. Reg. 62968, 62968 (Dec. 6, 1994) (issuing an interim final rule with comment and asserting that good cause under Section 553 is appropriate because the changes “essentially restore[] the regulations to the wording which was originally promulgated”); 52 Fed. Reg. 47926, 47931-32 (Dec. 17, 1987) (adopting a “conforming change” to align the regulatory text to the statutory provisions and appropriations documents such that “notice and comment would be unnecessary and contrary to the public interest”); 51 Fed. Reg. 47178, 47178-79 (Dec. 30, 1986) (issuing an interim final rule with comment while asserting that there is good cause under Section 553 to bypass notice and comment rulemaking procedures and a delay in the rule’s effective date); 43 Fed. Reg. 4570, 4570 (Feb. 2, 1978) (waiving a notice of proposed rulemaking and a delayed effective date because of “the compelling need to provide immediate direction to States and Federal grantees . . . and to follow the dictates of Congress that the Department promptly issue regulations”).

³⁹ 47 Fed. Reg. 4016, 4016-19 (Jan. 27, 1982). In the notice of proposed rulemaking, HHS included exceptions for endangering the life of the mother and in instances of rape or incest. However, Congress subsequently removed the rape and incest exceptions from the Hyde Amendment. So, in the final rule, HHS restricted coverage to only instances where the life of the mother would be endangered if the fetus were carried to term.

⁴⁰ See, e.g., 65 Fed. Reg. 33616, 33631 (May 24, 2000) (issuing a rule to implement the Hyde Amendment for CHIP); see also 66 Fed. Reg. 2490, 2567-68 (Jan. 11, 2001).

⁴¹ While agencies could argue that revisions to Hyde rules qualify as interpretive rules or agency organization, procedure, or practice under Section 553(b)(A) of the Administrative Procedure Act (such that notice and comment rulemaking procedures are not needed to adopt these changes), this memorandum does not recommend that approach. See Chamber of Com. of U.S. v. Occupational Safety & Health Admin., 636 F.2d 464, 469 (D.C. Cir. 1980) (“[I]nterpretive rules ‘are statements as to what the administrative officer thinks the statute or regulation means.’ Such rules only provide a ‘clarification of statutory language,’ the interpreting agency only ‘reminds affected parties of existing duties.’”); Mann Constr., Inc. v. United States, 27 F.4th 1138, 1143 (6th Cir. 2022) (“[I]nterpretive rules articulate what an agency thinks a statute means or remind parties of pre-existing duties.”).

Precedent For Updating Hyde Regulations

There is precedent for updating agency rules to interpret the Hyde Amendment. Agencies have interpreted and reinterpreted the Hyde Amendment since the late 1970s by issuing both new rules and updated guidance.⁴² Still other agencies, such as the Departments of Defense and Justice, have implemented Hyde Amendment restrictions in manuals or policy statements that can be updated even more easily than rules.

Some of these revisions have been litigated. In *Elizabeth Blackwell Health Center for Women v. Knoll*, abortion providers argued that Pennsylvania's reporting and physician certification requirements for Medicaid-funded abortions were preempted by an HHS letter to state Medicaid directors.⁴³ As noted above, this 1993 guidance (1) affirmed that state Medicaid programs could not impose reporting or documentation requirements that deny or impede coverage for abortions; and (2) created a waiver of reporting or documentation requirements if a physician certified that a patient was unable to comply with those requirements for physical or psychological reasons.⁴⁴ Pennsylvania, in contrast, imposed stringent reporting requirements with no option for waiver.

Finding that the HHS guidance was a reasonable interpretative rule that reconciled competing interests of the Medicaid statute and Hyde Amendment, the Third Circuit Court of Appeals held that HHS's interpretation was entitled to *Chevron* deference and invalidated Pennsylvania's requirements.⁴⁵ Pennsylvania's restrictions deprived women of a federal benefit that would otherwise be available in accordance with HHS's guidance and were thus preempted.

HHS and other Hyde-covered agencies should have the same flexibility now as they did then to interpret the Hyde Amendment in a way that balances the interests of women covered by the Medicaid program and annual appropriations riders. Modernizing Hyde regulations in the ways identified above would serve Congress's goal of limiting public funding for abortions while also recognizing some abortions should be covered by federal funds.

V. Risk Analysis

There is litigation risk in modernizing Hyde regulations, especially given the potentially preemptive effect of Hyde rules on state Medicaid programs. Legal challenges would be filed by stakeholders that have relied on the current interpretations and believe that agencies do not have authority to shift their interpretation or modernize Hyde requirements. Stakeholders might challenge such rules as procedurally and substantively invalid under the Administrative Procedure Act, arguing that the interpretations noted above are arbitrary and capricious, contrary to law, and should not be afforded *Chevron* deference. Revised rules would be more susceptible to invalidation if agencies bypass notice and comment rulemaking procedures and instead cite good cause or issue interpretive rules.

⁴² See 44 Fed. Reg. at 61598. HHS first adopted a rule to implement the Hyde Amendment for Medicaid in 1978. See 43 Fed. Reg. 45176 (Sep. 29, 1978).

⁴³ Knoll, 61 F.3d at 182.

⁴⁴ Richardson, *supra* note 23 (describing the 1993 guidance).

⁴⁵ *But see* Utah Women's Clinic, Inc. v. Graham, 892 F. Supp. 1379, 1382 (D. Utah 1995) (noting that the plain language of the Hyde Amendment was unambiguous and therefore HHS's guidance from 1993 was not entitled to *Chevron* deference). The court's commentary on *Chevron* was dicta because the court was already bound by the Tenth Circuit's decision in *Hern v. Beye*, 57 F.3d 906 (10th Cir. 1995) that held that under Medicaid, states could not decline to cover abortions for victims of rape or incest.

States, in particular, will argue that agency officials have exceeded their statutory authority. They might argue that the proposed policies are inconsistent with the text of the Hyde Amendment and impermissibly prioritize the health of the mother over the fetus. They might also argue that revised HHS rules would force state Medicaid programs to fund abortion even though the Hyde Amendment does not *mandate* Medicaid coverage of abortion for Hyde exceptions. States certainly would oppose, and challenge in court, any Medicaid regulations or guidance that go beyond the exact text of the Hyde Amendment.

Agencies should acknowledge all reliance interests, even if consideration of these interests does not change the policy.⁴⁶ These concerns could be neutralized by noting that (1) the agency is not imposing new requirements and is rather clarifying existing statutory standards; (2) the agency is codifying existing guidance, such as HHS's 1993 guidance, rather than making a substantive change; and (3) the agency is eliminating outdated restrictions that reflect prior, more restrictive Hyde Amendment language that have since been rejected by Congress. Overall, any concerns associated with the changes are outweighed by the need to modernize prior rules to comply with existing law and help ensure that women can access covered abortion services.

Agencies should also consider whether changes are needed to ensure proper enforcement of Hyde Amendment requirements. HHS may, for instance, need to amend current Medicaid forms to collect more information on the coverage of abortion for Hyde exceptions.⁴⁷ Enforcement by federal agencies may be necessary if states fail to allow coverage for Hyde exceptions—whether under current or revised Hyde rules.

⁴⁶ See *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515, (2009) (noting that it would be arbitrary or capricious for an agency to ignore the reliance interest engendered by prior agency policy by issuing new policy without reasoned explanation).

⁴⁷ U.S. Government Accountability Office, *supra* note 31.