Ibis Reproductive Health

Research brief: The impact of out-of-pocket costs on abortion care access

ALL ABOVE ALL

SEPTEMBER 2016

OVERVIEW

The decision to have a child has significant implications for a woman's financial well-being, educational attainment, and workforce participation. Access to affordable, comprehensive reproductive health care services, inclusive of abortion care, ensures that women and their families, regardless of financial and insurance status, can make this decision when they are ready.

A 2014 Commonwealth Fund study of high income countries ranked the US healthcare system last in terms of access and equity, due in part to high out-of-pocket spending requirements[1]. The average US resident spent $1,074 out-of-pocket (OOP) in copayments for doctor's office visits, prescription drugs, health insurance deductibles, and other health care costs in 2013[1]. These expenses, when viewed in the context of findings from a government survey showing that "47% of Americans were unable to come up with $400 in an emergency using cash or funds in their existing checking/savings accounts or on a credit card that they could pay in full by the next billing cycle"[2], help explain associations found between OOP costs and public health indicators such as decreased treatment adherence[3,4], and delayed 'needed' care[5].

Average OOP costs for an abortion range from $397 for a first trimester abortion to $854 for a second-trimester abortion[6], a cost that—based on the report cited above—is out of reach for the average American. Given that 42 percent of women seeking an abortion have household income below the federal poverty level in the United States[7], these high OOP costs result in inequitable access to abortion services and an exacerbation of existing reproductive health disparities.

Health insurance funding and coverage bans in the United States limit access to care for women who cannot pay the significant OOP costs for these services. Congress has enacted numerous policies that prohibit funding of abortion at the federal level, impacting nearly all women who rely on federal programs for their health care needs. One such policy is the Hyde Amendment which bars the federal Medicaid health insurance program from covering abortion care. Currently, 52% of women covered by Medicaid— approximately 7.4 million women—live in states that also extend these restrictions to their state Medicaid program, providing abortion coverage for only those women who meet the highly limited Hyde exceptions—women whose lives are in danger or whose pregnancies are the result of rape or incest[8]. Because low-income women and women of color are disproportionately covered by public health insurance programs, restrictions in coverage increase their socioeconomic disadvantage. Addressing high OOP costs will go a long way to ensuring all women have access to safe and affordable abortion care services and to reducing negative impacts on household security for women and their families as they struggle to find OOP funds.

For this report, we reviewed published literature, papers under submission, and other publicly available information on the costs of abortion care to document:

- the current OOP cost landscape for abortion in the United States;
- factors contributing to OOP costs for abortion services at the policy, health care provider, and individual level
- the impact of OOP expenses on US women's abortion access; and
- public health and policy strategies that would move us towards reducing OOP costs for abortion care

Our findings suggest that OOP costs play a fundamental role, one that is often underestimated, in the discussion of abortion access in the United States.

FINDINGS

OOP costs for abortions in the United States

The majority of women seeking abortion care are between the ages 20-29, non-White, and have had at least one previous birth[9]. Data from the Guttmacher Institute's most recent abortion patient survey found that 49% of abortion patients had incomes less than 100% of the federal poverty level. Approximately 72% of abortion patients reported having some type of health insurance and 24% used Medicaid coverage to pay for their abortion[9]. Regardless of insurance coverage, 53% of abortion patients in the Guttmacher survey reported paying OOP for their abortion[9]. This proportion is similar to results from a national survey conducted between 2008 and 2009 of US abortion patients (n=9493) that reported 57% paid OOP for abortion services[7]; qualitative research with smaller selected samples of women has shown that a higher proportion of women—upwards of 75%— paid OOP for their abortion care and that proportion varied by state[10,11].

Irrespective of insurance coverage, **53%** of US abortion patients paid for their abortion themselves

In the articles we reviewed, costs for a clinic-based abortion in the United States were most often provided as mean and median costs; costs varied by gestational age, abortion procedure, type of facility, and caseload[6,11-17]. In general, costs increased with gestational age[13,17], were most expensive at physician's offices[13], and least expensive at facilities with larger caseloads[13]. Data from the Turnaway study, a study of women seeking abortion care at 30 facilities across the United States[17], found that abortion costs on average were $506 for a first-trimester aspiration procedure, and $461 for a first-trimester medication abortion. For abortions at 14-19 weeks, the average cost was $860, while abortions 20 weeks and over cost on average $1874.

Women typically pay 70-80% of the total cost for an abortion at less than 20 weeks

On average, OOP costs were $304 for a first trimester surgical abortion, $365 for a first-trimester medication abortion, $638 for an abortion 14-19 weeks, and $656 for an abortion 20 weeks and over. Women paid 70-80% of the total costs for an abortion less than 20 weeks and about 35% of the total costs for abortions over 20 weeks. When women are covered for abortion services, studies show the majority pay $20 or less in OOP costs[17].

For many women, especially the 42% reporting incomes below the federal poverty level, paying for an abortion represents a substantial cost. Roberts et al specifically asked women how their abortion costs compared to their income, and 56% said OOP costs were more than one-third of their monthly personal income[17]. Abortion OOP costs have also been shown to be higher than other typical health care expenses for individuals aged 25-34, who are more likely to be uninsured and seek abortion care[18]. Phillips et al, using nationally representative data from a government survey, showed that the median OOP cost for a first trimester medication abortion ($440) was nearly twice the annual median OOP cost for health care ($258)[18]. This difference between median OOP cost is even more striking for abortions beyond the first trimester but less than 20 weeks (~3 times higher) and 20 weeks or higher (~7 times higher).

Determinants of abortion OOP costs in the United States

Several articles in our review described factors contributing to OOP costs for abortion services at the policy, provider, and individual level.

At the policy level: Insurance coverage of abortion—unlike other health care services—is determined by laws at both the federal and state level. The Hyde Amendment, included yearly in appropriations legislation, specifies federal funds cannot be used to cover abortions for those enrolled in Medicaid unless the woman's life is in danger, or the pregnancy is a result of rape or incest. Over the years, politicians added this language into further legislation to deny coverage to federal employees and their dependents, military service members, Native Americans, Peace Corps volunteers and others[19]. Currently, 32 states and the District of Columbia follow the specifications of the Hyde Amendment[8]. Remaining states use state-only funds to extend abortion coverage for women on Medicaid beyond the federal limitations of the Hyde Amendment. Restrictions within the Affordable Care Act (ACA) have effectively limited abortion coverage in plans included in ACA health insurance exchanges[20]. As of 2016, women residing in 31 states cannot find insurance coverage for abortion care through a plan offered on health exchanges[8]. Six of these 31 states do not offer plans that include abortion coverage, while the remaining 25 states have enacted laws prohibiting all plans in their state marketplace from covering abortion[8]. For women residing in one of the remaining 19 states with a plan that covers abortion, coverage may still be absent, as the availability of these plans varies by county[8]. While some states have chosen to extend the ban on abortion coverage to private plans, other states have further narrowed the reasons under which a woman is permitted to have her abortion covered under a private plan[8]. These variations in coverage add to the complexity for women seeking abortion coverage and access.

7.4 million women live in states that restrict abortion coverage in accordance with the Hyde Amendment

At the health care provider level: Three qualitative studies have documented the burden that health care providers face in 12 states where Medicaid only covers abortion based on the Hyde exceptions. Providers described significant challenges receiving and/or applying for Medicaid reimbursement when a woman's procedure qualified for coverage based on the eligible Hyde exceptions. In two studies, disagreements around the interpretation of "life-endangerment"[11, 21] and "rape"[11, 21] and difficulties identifying and documenting rape cases by staff in state Medicaid offices[11] were cited as reasons the clinic did not receive reimbursement for abortion services that should have qualified for Medicaid funding[11,21].

> *"We [providers]….may believe an abortion is necessary to save the life of a pregnant woman. Oftentimes, when it goes to Medicaid, they don't agree with that assessment."*[21]

Providers and administrative staff at clinics also cited significant bureaucratic paperwork, extensive staff time to complete the paperwork, and delays in communication from the Medicaid office as reasons the clinic did not receive reimbursement[11,21,22]. The burden of working with Medicaid became an impenetrable barrier for some, to the extent that some providers stopped working with Medicaid.

> *"We cannot get a Medicaid referral because we are not a Medicaid provider, but we are not a Medicaid provider because they seldom ever pay for abortions."*[11]

Together, these reimbursement challenges contribute to OOP costs for low-income women, as they now have fewer providers that will accept their insurance.

At the individual level: Even in states with Medicaid coverage of abortion, approximately eight percent of women who

would be eligible for Medicaid do not obtain coverage for their abortion, likely a result of challenges associated with recognizing eligibility and enrollment into Medicaid[23]. Women reported conversations with Medicaid staff and insurance plan representatives where the staff/representatives were uncertain or did not clearly explain abortion coverage under their insurance plans[24,25]. Additionally, Medicaid staff provided information that contradicted state or federal policy[25]. As a result, in some cases women do not end up using their insurance to cover their abortion because they do not think the procedure is covered by their plan[6].

Similar to the challenges health care providers face, women who seek insurance coverage when they qualify based on the Hyde exceptions experience delays in care due to differing definitions of rape and life endangerment. Women are often asked to provide supporting documentation as proof their abortion meets the criteria for coverage, while the conflicting definitions and interpretations of the coverage restrictions often make it unclear which documents need to be submitted[11,21,25].

Other delays in care are related to complications and confusion with the Medicaid enrollment process[26]. For example, in a study of women seeking state-subsidized insurance for abortion care in Massachusetts—one of the seventeen states that cover abortion with state funds—women reported that the state insurance system was complicated and confusing, and said that delays in the enrollment process were often due to errors and missing forms or documents[26]. These delays not only impact the types of abortion procedures a woman can choose (because medication abortion is only available early in pregnancy), but also lead to increased OOP costs for women unable to secure coverage in time for an earlier procedure who then get a later, costlier, procedure[26].

Finally, stigma associated with abortion leads some women to choose to pay OOP for their abortion rather than using insurance. In a qualitative study by Dennis et al, women reported opting to pay OOP due to fear of someone finding out about the abortion. In one case, a young woman, who relied on insurance from a parent, paid OOP to avoid a parent finding out about the abortion[10].

Impact of abortion OOP costs

The majority of women seeking an abortion in the last year had reported experiencing one or more disruptive events, such as being unemployed or falling behind on their rent or mortgage[27]. Abortions are unexpected events and for women already struggling to make ends meet, abortion health expenditures at an average OOP cost of $365 are catastrophic. A 24-year old non-Hispanic White woman summed it up best when she said:

> *"I know a lot of people that have had an abortion. Most of my friends and a lot of my family members have. I just know that every time I know somebody who has to go through that, it's a struggle having to come up with the money because they're very rarely covered by health insurance. So, even my friends that have insurance still have to pay out-of-pocket for their abortions, and you know it's unexpected. I mean women don't know that they're going to have to have one, we don't plan for that. We don't put away a fund for it or anything. So it's really an unexpected expense, and I know a lot of people that have been really burdened by it."*[10]

A review of funding provided by the National Network of Abortion Funds to 2959 US women between 2010-2014 showed that women were generally able to raise less than one-quarter of the cost of an average abortion[12]. The search for financial resources to pay OOP costs can delay women from obtaining abortion care, forcing some women to have later abortions and increasing the costs and potential health risks of an unintended pregnancy[28,29]. To afford care, some women endure financial hardships such as forgoing food or schooling, forgoing work, taking out payday or other loans, delaying bills or rent, putting large amounts on credit cards, and pawning belongings[10,16,17,21,30-34]. One 27-year old, low-income, Black woman described her path to finding funding for her abortion:

> *"I did a payday loan against my [pay] check. Some bills did not get paid. […]. I didn't send my daughter to preschool. […] whatever money I had to pay for other stuff, I was trying to save and hustle it. I actually pawned some of my jewelry as well."*[10]

For some women, the cost of an abortion extends beyond $365 for a clinic based abortion and includes secondary costs such as lost wages (~ $198), hotel costs (~$140), and childcare (~$57)[6]. Furthermore, because some states prohibit abortions after certain gestational ages, women who are delayed due to financial reasons may have to travel to states that permit later abortions; this leads to additional costs and burdens[6,28,35-38].

Extant literature reports that in the absence of Medicaid assistance, one in four low income women who desire an abortion are forced to carry their pregnancies to term[39]. Studies on the experience and outcomes of unintended or unwanted pregnancies show that, even in circumstances of adequate economic resources, women and children are more likely to experience poorer birth outcomes such as low birth weight[40] and poorer social and psychological outcomes including lower self-esteem, lower educational attainment, and more behavioral issues during adolescence[41-44]. Results from the Turnaway study show that women denied an abortion were three times more likely to end up below the federal poverty line two years later[45]. In contrast, ensuring abortion access enabled women to achieve aspirational goals related to education, employment, and change in residence[46].

Addressing the burden of high OOP costs

In the face of high OOP costs, half of all women seeking abortions rely on assistance from other sources to cover their abortion[6]. One such source is abortion funds—grassroots organizations that help fill the "payment gap" for some abortion seekers. In a random sampling of 9493 women who obtained an abortion in the United States in 2008, 13% reported relying on financial assistance programs such as abortion funds to

Median OOP cost for a first trimester abortion is 2x the annual median OOP cost for other health care

cover service costs[7]. More recent survey results not only show similar proportions of abortion patients receiving financial assistance, but also note an increase in funding requests from women at later gestational ages, suggesting that despite the promises of better comprehensive coverage through health care reform, barriers to abortion coverage push women later into a pregnancy and result in an increased need for informal sector funding[12]. Beyond providing financial assistance, abortion funds can act as an important source of information about and referrals to subsidized health insurance in states that use their own funds to cover abortion costs. Many women referred by Massachusetts abortion funds to state-subsidized health insurance characterized abortion funds as a "helpful gateway" to insurance enrollment[47]. Of note, abortion funds are dependent on donations and because of limited funding they are not able to cover all women seeking assistance. As a result, many funds are forced to prioritize each case based on need or the complexity or cost of the procedure[12].

A number of other indirect and ad hoc solutions involve "work-arounds" for the Medicaid reimbursement process. In one study, providers mentioned that they involved clients in the reimbursement process by having them contact Medicaid and ask why a qualifying abortion wasn't being covered. While participating in the reimbursement process may be empowering for some women, other women "feel overwhelmed or further victimized by the process"[22]. Some clinics have worked to build relationships with the Medicaid staff to help smooth the reimbursement and billing process, with the downside of diverting staff time from patient care and other priorities[22], while others "eat the cost" of the procedure by providing discounted services and sometimes suffered financially for it[21]. Neither the current direct nor indirect solutions are ideal or sustainable.

Advocating for improved abortion care access

Abortion care is a key component of comprehensive women's reproductive health care. However, the cost of an abortion is a major hurdle for women seeking them. This barrier is even more insurmountable for women living below the federal poverty line, who rely on federal assistance for their health care needs. Women have a right to good reproductive and sexual health and that means having access to the care they need, where and when they need it.

To improve women's abortion care access and promote the health and wellbeing of women and their families, the availability of abortion services and coverage for abortion care must be expanded. Public health and policy strategies that reduce OOP costs will be crucial to this expansion effort and must address root causes such as prohibitions on coverage, low insurance reimbursement rates, and abortion stigma.

1. **Lift restrictions that deny health coverage of abortion services through public and private insurance**

    a. At the federal level, the passage of the Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act of 2015 (H.R.2972) would ensure that a woman's decision about abortion is not based on her income, how she is insured, or where she lives. This legislation ensures that if a woman gets her care or insurance through the federal government, she will be covered for all pregnancy-related care, including abortion. The EACH Woman Act also prohibits political interference with decisions of private health insurance companies to offer coverage for abortion care. Federal, state, and local legislators will not be able to interfere with the private insurance market to prevent insurance companies from providing abortion coverage.

    b. Also, we recommend the 35 states that deny Medicaid coverage from their citizens insured by the state's Medicaid program to begin using their own funds to cover this care. Although abortion funds fill a critical gap in the US health care system caused by funding restrictions such as the Hyde Amendment, these funds cannot meet the needs of all women.

2. **Address the challenge of access and provision of services related to enrollment complexities and varied interpretations around eligibility for Medicaid**

    a. Where there is coverage of abortion care (full or limited), a better understanding of Medicaid processes and definitions related to abortion coverage will reduce uncertainty in cases that meet the criteria and therefore can be covered. This improvement in knowledge will help reduce the numbers of women paying OOP, while increasing the numbers of providers getting reimbursed for abortion services.

    b. A 2016 Kaiser Family Foundation report states that 29% of currently uninsured women could enroll in a Medicaid or private insurance plan that does not limit the scope of coverage for abortion services[8]. However, given the reported complexity of the enrollment process, it is likely that a portion of these women who could enroll will not. Simplifying the Medicaid enrollment process will remove this barrier for women eligible for coverage.

3. **Address concerns with privacy for abortion care services**

    a. Instituting state-level insurance statutes and regulations that prevent policyholders from being notified if insurance is used for an abortion or prevent an abortion from being listed on their insurance will alleviate women's concerns about the privacy of their health information.

    b. Increasing funding for and dissemination of public health initiatives that target abortion stigma may help empower women, fearful of 'abortion outing', with coverage to use that benefit.

Conclusion

Accessing abortion care services is costly for women in the United States. Since the average American cannot come up with $400 to cover unexpected health expenditures, the OOP costs for an abortion are likely to have a significant impact on the financial security of women seeking an abortion. Addressing barriers related to access such as cost is imperative to protecting women's reproductive health and will help to bolster associated socioeconomic outcomes such as educational attainment and job participation.

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