Ibis Reproductive Health

Abortion as a catastrophic health expenditure in the United States

Background

In the United States, abortion care is financially inaccessible for many individuals. Seventy-five percent of abortion patients in the United States have low incomes and almost half earn incomes below the federal poverty level,[1] making the estimated average 2020 cost of an abortion ($465 for a first-trimester abortion and $1,038 for a second-trimester abortion) extremely difficult or impossible for many abortion seekers to pay out-of-pocket.[2,3] In 2019, 37% of US adults were not able to cover a $400 emergency expense with cash or a credit card they could pay off at the end of the month,[4] and with millions of people reporting job loss or reduced work hours due to the COVID-19 pandemic,[5] the percentage of Americans experiencing financial hardship was likely higher in 2020 than in previous years.

Although insurance coverage of abortion would protect people from experiencing financial hardship for obtaining this essential reproductive health care service, policies at the federal and state level continue to restrict insurance coverage of abortion. At the federal level, the Hyde Amendment prevents federal funds contributed to Medicaid (which assists with medical costs for people earning low incomes) from being used for abortion, except in very limited circumstances.[6,7] Legislators in many states have implemented policies to restrict private insurance plans and plans offered in health insurance marketplaces from offering abortion coverage, further limiting financial access to abortion.[8]

Without insurance coverage, abortion seekers must either find a way to pay out-of-pocket or carry an unwanted pregnancy to term. When out-of-pocket spending for a health service is above a certain proportion of one's income, this cost is considered a catastrophic health expenditure (CHE). To understand the extent to which out-of-pocket abortion costs impact the financial wellbeing of US households, we assessed whether abortion costs could be considered a CHE for households earning their state's median income.

Methods

The World Health Organization defines a CHE as a cost that is 40% or more of a household's monthly non-subsistence income (income remaining after basic needs have been met).[9] We used this definition for our calculations because it has been applied to the cost of reproductive health services in various countries with different health care systems (see Appendix 1), including the cost of emergency cesarean sections,[10] which is comparable to abortion in that it is an unanticipated and time-sensitive reproductive health service.

To assess whether estimated 2016 out-of-pocket costs for first- and second-trimester abortions qualified as CHEs, we used median household income data for each state and Washington, DC, in 2016 inflation-adjusted US dollars gathered by the US Census Bureau through the American Community Survey.[11] Annual state median income was converted to and analyzed as monthly income because abortion is an emergency expenditure for a non-chronic condition that would most strongly impact one's income during the month the procedure occurred.

Estimates on the minimum wage (living wage) for each state and Washington, DC, took into account expenses for food, child care, health, housing, transportation, taxes, and other necessities, such as clothing and personal care items.[12] Based on data showing that over half of abortion patients have had at least one previous birth (59%) and are not living with a partner the month they become pregnant (54%),[1] we decided to use living wage data for households with one full-time working adult and one child.

FINDINGS

First-trimester abortion as a CHE

We found that the 2016 average out-of-pocket cost of a first-trimester abortion procedure ($427) would have been catastrophic for households earning their state's median monthly income in 39 states. In nine of these states, this cost was between 100-199% of a household's non-subsistence income, and in another nine states, it was at least double a household's monthly non-subsistence income.

Second-trimester abortion as a CHE

The 2016 out-of-pocket average cost of a second-trimester abortion ($919) would have been catastrophic for households earning their state's median monthly income in all 50 states and Washington, DC.

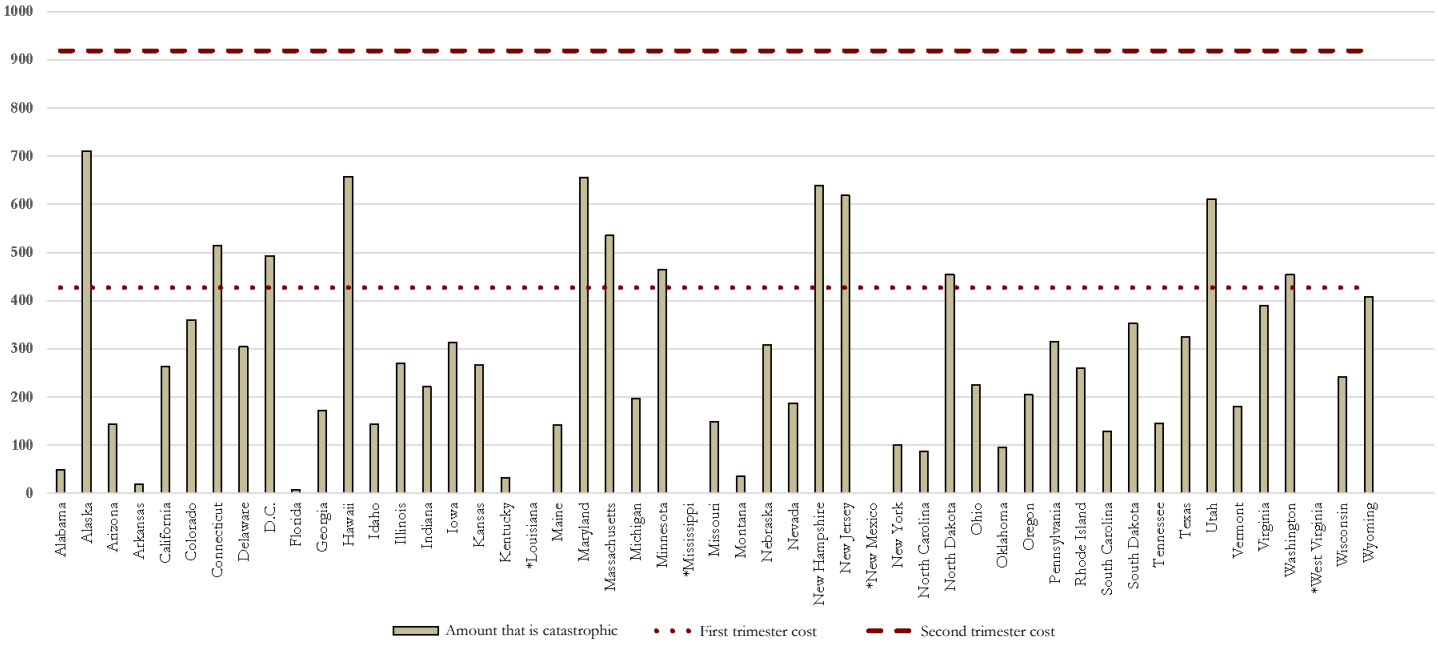
Impact of state policies on abortion coverage for people seeking abortions

Of the 39 states where the average out-of-pocket cost of a first-trimester abortion would be a CHE, 31 states have implemented policies restricting insurance coverage of abortion.[8,13] All 31 states prevent Medicaid recipients from using their insurance to cover the cost of abortion except in very few circumstances,[13] and nine states have restrictions on private insurance plans,[8] which means that even individuals with private insurance who live in median-income households would experience the cost of a first-trimester abortion as a CHE in these states. In addition, 24 of these 31 states place Hyde-like restrictions on plans offered in health insurance marketplaces.[8]

In the other eight states, Medicaid funds are used to cover all or most medically necessary abortions,[13] so individuals earning low incomes would not experience the cost of an abortion as a CHE. In addition, five of these eight states also require private insurance plans to cover abortion care,[8] providing a safety net for individuals who qualify for coverage through a marketplace plan or who are on an employer-based plan.

Of the 50 states where the average out-of-pocket cost of a second-trimester abortion would be a CHE, abortion seekers in only six states would be able to use their insurance (private or public) to cover their abortion. An additional ten states use state funds to cover abortion for Medicaid recipients.[13]

Figure 1: Amount catastrophic to households, compared to abortion costs



Discussion

In most states, the out-of-pocket cost for a first- and second-trimester abortion is financially catastrophic for households with one adult and one child earning the median monthly income. Previous research has shown that abortion seekers with limited finances sacrifice food or other basic necessities[3,14,15] or take on financial risk—such as taking out a payday, other loans,[15] or relying heavily on credit cards[15-17]—to afford an abortion. The time spent trying to obtain enough money for an abortion may lead to delays to care,[18-20] which may result in some people choosing between a more expensive second-trimester abortion or not having a wanted abortion at all. In addition to the cost of the procedure itself, many abortion seekers must consider costs related to accessing care, including travel expenses, lost wages from time taken off work, and child care costs.[21] It is also important to note that individuals unable to afford an abortion would also be the ones most impacted by child care costs, which could have long-term negative economic consequences[22] and developmental impacts on existing children.[23]

Policy implications

As a step toward ensuring access to comprehensive sexual and reproductive health care in the United States, policymakers at the federal, state, and municipal levels need to implement legislation founded on the principle that abortion is a critical reproductive health service that should be available to all, regardless of income or insurance status. Policymakers should:

- Require both private and public insurance plans to cover evidence-based abortion counseling and abortion services so that individuals with insurance will not experience financial hardship for accessing abortion care
- After ensuring Medicaid covers abortion, expand Medicaid eligibility requirements so that abortion is financially accessible to more individuals with limited incomes and resources
- Implement policies or programs that provide a safety net for all US residents so that uninsured individuals can access abortion without experiencing the cost of an abortion as a CHE
- Eliminate polices that erect unnecessary financial and logistical barriers for abortion seekers, such as laws that:
    - ◊ Require a waiting period between receiving abortion counseling and obtaining care, which forces abortion seekers to travel to a health clinic twice
    - ◊ Place unnecessary restrictions on providers and clinics in an attempt to reduce the availability of abortion services, resulting in clinic closures that force abortion seekers to travel long distances to access abortion care
    - ◊ Ban telemedicine for medication abortion or require patients to receive an ultrasound before a medical abortion

Read our full CHE analysis on abortion costs and potential policies that could prevent abortion seekers from experiencing financial hardship on **ibisreproductivehealth.org**.

References

1. Jerman J, Jones RK, Onda T. Characteristics of US abortion patients in 2014 and changes since 2008. 2016. https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf (accessed 22 May 2018).
2. Bureau of Labor Statistics. CPI inflation calculator. 2020. https://www.bls.gov/data/inflation_calculator.htm (accessed 22 May 2018).
3. Jones RK, Upadhyay UD, Weitz TA. At what cost? Payment for abortion care by US women. *Women's Health Issues* 2013;23:e173–8. doi:10.1016/j.whi.2013.03.001
4. Reserve Board F. Report on the economic well-being of US households in 2019, featuring supplemental data from April 2020, May 2020. https://www.federalreserve.gov/publications/default.htm (accessed 2 Nov 2020).
5. United States Bureau of Labor Statistics. Effects of the coronavirus COVID-19 pandemic (CPS). https://www.bls.gov/cps/effects-of-the-coronavirus-covid-19-pandemic.htm#highlights (accessed 2 Nov 2020).
6. H.R.2740, Labor, Health and Human Services, Education, Defense, State, Foreign Operations, and Energy and Water Development Appropriations Act, 116th Congress, 2019-2020. 2019.
7. Salganicoff A, Sobel L, Ramaswamy A. The Hyde Amendment and coverage for abortion services. 2020. https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services/ (accessed 11 Mar 2020).
8. Guttmacher Institute. Regulating insurance coverage of abortion. 2020. https://www.guttmacher.org/state-policy/explore/regulating-insurance-coverage-abortion (accessed 10 Mar 2020).
9. World Health Organization Department of Health Systems Financing. Technical briefs for policy makers: Designing health finance systems to reduce catastrophic health expenditures. 2005. https://www.who.int/health_financing/documents/pb_e_05_2-cata_sys.pdf (accessed 2 Nov 2020).
10. Honda A, Randaoharison PG, Matsui M. Affordability of emergency obstetric and neonatal care at public hospitals in Madagascar. Reproductive Health Matters 2011;19:10–20. doi:10.1016/S0968-8080(11)37559-3doi.org/10.1016/S0968-8080(11)37559-3
11. Guzman G. Household income: 2016. 2017. www.census.gov/acs (accessed 26 Feb 2019).
12. Glasmeier A. Living wage calculator. 2018. https://livingwage.mit.edu/ (accessed 20 Nov 2018).
13. Guttmacher Institute. State funding of abortion under Medicaid. 2020. https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid (accessed 10 Mar 2020).
14. Center for Reproductive Rights. Whose choice? How the Hyde Amendment harms poor women. 2010. https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Hyde_Report_FINAL_nospreads.pdf (accessed 27 Apr 2019).
15. Dennis A, Manski R, Blanchard K. Does Medicaid coverage matter?: A qualitative multi-state study of abortion affordability for low-income women. J Health Care Poor Underserved 2014;25:1571–85. doi:10.1353/hpu.2014.0151
16. Dennis A, Blanchard K. Abortion providers' experiences with Medicaid abortion coverage policies: a qualitative multistate study. Health Serv Res 2013;48:236–52. doi:10.1111/j.1475-6773.2012.01443.x
17. Nickerson A, Manski R, Dennis A. A qualitative investigation of low-income abortion clients' attitudes toward public funding for abortion. Women Health 2014;54:672–86. doi:10.1080/03630242.2014.919984
18. Finer LB, Frohwirth LF, Dauphinee LA, et al. Timing of steps and reasons for delays in obtaining abortions in the United States. Contraception 2006;74:334–44. doi:10.1016/j.contraception.2006.04.010
19. Jerman J, Frohwirth L, Kavanaugh ML, et al. Barriers to abortion care and their consequences for patients traveling for services: Qualitative findings from two states. Perspect Sex Reprod Health 2017;49:95–102. doi:10.1363/psrh.12024

20. Kiley JW, Yee LM, Niemi CM, et al. Delays in request for pregnancy termination: Comparison of patients in the first and second trimesters. Contraception 2010;81:446–51. doi:10.1016/j.contraception.2009.12.021

21. Upadhyay UD, Weitz TA, Jones RK, et al. Denial of abortion because of provider gestational age limits in the United States. Am J Public Health 2014;104:1687–94. doi:10.2105/AJPH.2013.301378

22. Foster DG, Biggs MA, Raifman S, et al. Comparison of health, development, maternal bonding, and poverty among children born after denial of abortion vs after pregnancies subsequent to an abortion. JAMA Pediatr 2018;172:1053. doi:10.1001/jamapediatrics.2018.1785

23. Foster DG, Raifman SE, Gipson JD, et al. Effects of carrying an unwanted pregnancy to term on women's existing children. J Pediatr 2019;205:183-189.e1. doi:10.1016/j.jpeds.2018.09.026

24. Doe v. Bolton, 410 US 179. 1973.