

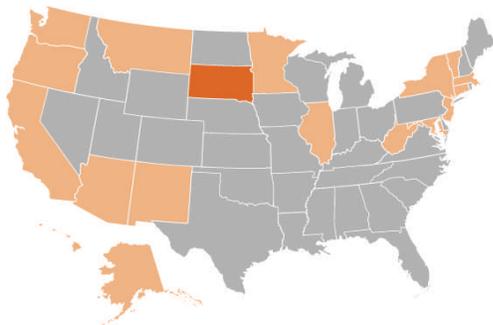
State-Level Research Brief

Public Funding for Abortion in Illinois

BACKGROUND

The Hyde Amendment, first approved by Congress in 1976, limits women's access to comprehensive reproductive health care by prohibiting federal Medicaid funding for abortion except when a woman is pregnant as a result of rape or incest, or when her pregnancy endangers her life. States have the option to cover abortion care using state funds in broader circumstances, but only 17 (including Illinois) currently do. Illinois is under court order to provide state Medicaid funds to cover all medically necessary abortions. However, abortion providers and women's health advocates in the state have reported that obtaining Medicaid reimbursement for abortion is extremely difficult. Therefore, many consider Illinois a state that does not allow Medicaid coverage of abortion at all, or one that only covers cases that meet the Hyde Amendment criteria, not the more expansive criteria of medically necessary abortions. According to reports from the Guttmacher Institute, a combination of state and federal funds were used to cover just over 100 abortions in Illinois in 2006, a marked increase from the 37 funded in 1994.¹⁻²

Medicaid Coverage of Abortion



- 32 states ban state Medicaid coverage of abortion. They are legally required to provide coverage in the cases of rape, incest, and life endangerment, but usually fail to do so.
- 17 states provide state Medicaid coverage of abortion for low-income women in most cases.
- One state provides Medicaid coverage only in cases of life endangerment.

STUDY DESCRIPTION

Ibis Reproductive Health documented the experiences of abortion providers seeking Medicaid reimbursement for abortions provided in cases of rape, incest, or life endangerment of the woman, circumstances that should qualify for Medicaid coverage under the Hyde Amendment. From 2007 to 2010, we conducted over 60 in-depth telephone interviews with abortion providers in 15 states (Arizona, Florida, Idaho, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, New York, Oregon, Pennsylvania, Rhode Island, Wisconsin, and Wyoming). We asked each provider to identify the person most knowledgeable about Medicaid funding in their

facility and interviewed physicians, physician assistants, clinic directors, managers, nurses, counselors, and financial administrators.³⁻⁴

FINDINGS

We interviewed eight providers, representing 11 practices, across the state of Illinois between October 2008 and March 2009.* Providers worked in abortion practices that varied in size, services offered, and annual case load; the practices provided an average of 1,827 abortions annually (range 175-5,798). Participants' age, educational background, and years of provision of abortion care also varied; the average age of the participants was 46 years and they had an average of 10 years of experience in the field.

Because of the significant confusion about the circumstances under which abortion should be covered by Medicaid in Illinois, we asked study participants to estimate both the number of abortions provided that should have been eligible for Medicaid funding under the Hyde Amendment and the number of medically necessary abortions provided to women on Medicaid. Providers estimated that, in the year prior to the interview, 423 women sought abortions that should have been eligible for Medicaid funding under the Hyde Amendment, but only 7% of those were reimbursed. Only one of the providers we spoke with reported success with Medicaid; this provider was reimbursed for 31 procedures provided in cases of rape, incest, and life endangerment in the previous 12 months. However, according to the Illinois court order, all medically necessary abortions provided to women on Medicaid should have been covered by Medicaid, not just those provided in cases of rape, incest, and life endangerment of the woman. This means that well over 2,000 procedures at the 11 practices where we conducted interviews should have been funded by Medicaid, but were not.

What are the reasons for the discrepancy between what should have been covered by Medicaid and what was actually reimbursed? Providers reported that there were a number of obstacles to securing Medicaid reimbursement including a large gap between the court-ordered Medicaid policies for abortion and what happens in practice, frequent Medicaid denials of qualifying claims, limited trust in Medicaid's ability to provide billing support, inadequate financial compensation from Medicaid for abortion care, and few providers maintaining contracts with Medicaid.

*One provider worked at three facilities and reported on all three of them.

Finding 1: There is confusion about the circumstances under which Medicaid is supposed to cover abortion due to significant gaps between law and practice

Most of the providers we interviewed reported they thought that Medicaid only covers abortion in Illinois in cases of rape, incest, and life endangerment. One provider explained, “The law here in Illinois does state that they will reimburse for those things – rape, incest, or life threatening due to the mother.” Another provider stated that, “If you look on the website [of Medicaid], or if you look in their handler’s manual, their providers’ manual [states] that they [Medicaid] cover this procedure in a case of rape, incest, or to protect the life of the mother.” Only one provider we spoke with indicated that she believed Medicaid provided coverage for medically necessary abortions. The confusion about the circumstances under which Medicaid covers abortion highlights the significant gaps between what Medicaid funds in practice and what the law states that Medicaid should cover.

Finding 2: Medicaid regularly denies reimbursement claims submitted for abortion care

Even though Illinois Medicaid is, by court order, supposed to provide coverage for all medically necessary abortions, providers reported that in practice, obtaining coverage for any procedure rarely, if ever, happens, even in cases of rape, incest, or life endangerment. One provider explained, “The woman who trained me has been in the business for 28 years and they have never been able to get assistance from public aid for any part of an abortion.” Another provider felt that Medicaid looked for reasons to deny claims. She said, “They are trying to find reasons as to why they should not cover even medically indicated [abortions].... They don’t want to cover [abortion], and they don’t want to leave this option available to women.”

Because of the lack of past success in securing reimbursement, most providers have given up on filing Medicaid claims for abortion under any circumstances. The few participants who said they do continue to apply for reimbursement described a frustrating and complex billing process in which they repeatedly submit claims to Medicaid for abortion in qualifying cases only to have them rejected for seemingly arbitrary or insignificant reasons. One participant said of her experience being denied by Medicaid for claims submitted, “If they don’t like the diagnostic code for some reason, they might say, ‘Oh, we can’t [reimburse]. Submit a different diagnostic code for this service.’” Another provider recalled submitting the same claim to Medicaid multiple times with little success: “They come back and say, ‘Oh, it can’t be paid, because the diagnosis code’s last number was printed on the line. ... The column was too far to the right.’” Only one provider, who worked in a hospital setting, reported successfully receiving

reimbursement from Medicaid for all medically necessary abortion procedures, not just the exceptions under the Hyde Amendment.

Finding 3: Providers have little trust in Medicaid’s ability to provide billing support

Providers reported they rarely seek help from Medicaid to resolve questions they have about obtaining funding for current cases or past denied claims. This appears to be due to past problems working with Medicaid and to a lack of a direct relationship with knowledgeable Medicaid personnel. One provider said, “We don’t have a real relationship with them. We literally use these services and fill out documentation. That’s it. But we don’t have a real relationship with them.” Another provider stated when they call Medicaid, “There’s always a different person, so you don’t really have representatives any more, like they used to.” Some providers said that when they have sought help from Medicaid staff to file claims for abortion services they have received misinformation about the availability of funding and therefore no longer reach out to Medicaid for billing support.

Finding 4: Financial compensation from Medicaid is low and slow

The one provider who reported successfully receiving reimbursement from Medicaid said that the claims process was very slow and the rate of reimbursement very low. She explained, “Medicaid pays extremely low, and it takes quite a bit of time to get the payment from them.” The provider reported that payments from Medicaid typically took between 90 and 120 days to process, and the reimbursement level was only “eight cents on the dollar.” When asked about potential causes for the long delays in reimbursement, the provider said, “I think it is just the way the Medicaid system is set up, period.... It’s just the way the system is set up for payment.”

Other providers reported that inadequate reimbursement from Medicaid was the reason they no longer apply for funding from them, explaining that the amount of energy it would take in order to file abortion claims is not worth the payout they would receive. As one provider said, “I think Medicaid needs to reevaluate the amount they are paying...and just literally reevaluate the system.” Another explained, “Certainly, the procedure needs to be reimbursed in a very reasonable way. Now, there are certain states that they get ‘reimbursement,’ and I put that in quotations, because it’s not even sufficient to cover the service. So, although they can sort of check it off on the books, like, ‘Oh, yes, public aid pays,’ but, it’s not nearly enough to make it worthwhile to do those procedures.”

Due to the inadequate reimbursement rates received from Medicaid, providers, abortion funds, and women themselves covered the costs of abortion care. Three providers offered routine discounts to Medicaid patients, ranging from \$25 to \$60. A number of providers reported frequently absorbing or writing off a portion of the bill when providing abortion care for some patients on Medicaid who could not afford the procedure. One provider stated, “If she cannot come up with that last hundred, and I can’t get it from other sources of funding, we will often just write it off.” Nearly all Illinois providers we interviewed indicated some level of reliance on abortion funds to help clients pay for abortion procedures.

Finding 5: Few abortion providers maintain contracts with Medicaid

Due to the multiple challenges of working with Medicaid, many providers reported they no longer contract with Medicaid. Most stated they have struggled in the past when working with Medicaid and have discontinued contracting with them. One provider described Medicaid coverage of abortion in Illinois as “pretty pathetic” and stated that if a woman wanted to use her Medicaid to pay for an abortion that “the problem is finding facilities that are actually contracted with the state that offer this type of service.”

SUMMARY

Our findings complement previous efforts by the Chicago-based organization Black Women for Reproductive Justice (BWRJ) to document the availability of Medicaid funding of abortion for women in Illinois. BWRJ found that Illinois funds approximately 100 abortions for low-income women annually⁵ out of the over 50,000 abortions that occur in the state every year.⁶ In their work, BWRJ identified three primary barriers to working with Medicaid: 1) the process of becoming a Medicaid provider is arduous and complex, 2) Medicaid takes a long time to reimburse providers, and 3) the reimbursement rates are low for abortion services.⁵ Our research confirms BWRJ’s findings, building the evidence that Illinois Medicaid does not meet the needs of women on Medicaid or abortion providers.

Many of the providers we spoke to no longer contract with Medicaid due to challenges working with them in the past. Indeed, few providers that we spoke with held current contracts with Medicaid and most providers were unclear about how to pursue a contract with Medicaid should they want one. However, few providers were interested in contracting with Medicaid due to the low reimbursement rates for services and

the slow processing time. Many reported that it was futile to contract with Medicaid given the lack of adequate reimbursement for abortion services and the hassle involved in getting reimbursed. From communication to claims procedures, almost every aspect of providers’ experiences with Medicaid was described as tedious and bureaucratic. Most providers reported it was more costly to pursue reimbursement from Medicaid than to reduce their fees or absorb costs.

In addition to these barriers, previously undocumented challenges to utilizing Medicaid funding emerged in this research. Many abortion providers and Medicaid staff appear to be confused about what abortion services Medicaid is supposed to cover due to significant gaps between law and practice. Most providers reported a long history of claims being denied by Medicaid, which understandably cemented their belief that Illinois Medicaid only covers abortion in cases of rape, incest, and life endangerment of the woman. Some providers found it

difficult to access correct information about services covered; as providers pursued denied claims, they were often given little, contradictory, or incorrect information from Medicaid.

What is occurring in Illinois is particularly troubling because the law, written to ensure women on Medicaid can use their insurance to pay for all medically necessary abortions, is blatantly not being upheld by Medicaid. With 15% of the state’s adult female population on

Medicaid,⁷ the success or failure of the Illinois Medicaid system has the potential to impact a large number of women.

It should be noted that because we interviewed only a sample of the 37 abortion providers working in Illinois,⁶ the experiences of all providers may not be represented. The experiences of some providers may be different from those represented here because of the apparent differences in how providers and local Medicaid offices interpret and apply the law.

NEXT STEPS

Evidence of the barriers faced by Illinois abortion providers can be utilized to challenge and improve the funding system in the state. Multiple strategies, some tested in other states and some novel, may help mitigate the challenges providers reported in seeking public funding for abortion care.

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One provider in Illinois described the merits of seeking funding from the county where abortion care was provided, rather than from the state. This provider's experience with public abortion funding represented a significant departure from the rest of providers in our study. The provider was employed by a county hospital that provides first-trimester abortions to women at a flat rate of \$50 per procedure, regardless of their reason for termination. The provider stated, "Our system runs very different. We have public funding, but it's not in the usual way that most people talk about public funding." The county in which the provider works covers the majority of costs for all abortions performed at the facility, eliminating the need to apply for reimbursement through Medicaid. The decision to use public funds for abortion is made by the county board, and is influenced by the board's political composition. The reduced cost of abortion has led to an incredible demand for services at the facility. The provider reported that they have a "tremendous backlog" of women who need care and that they receive over 4,000 calls a week for abortion services.

This model of abortion funding offered by the county is one that providers in other counties in Illinois may want to consider. This strategy has also been used in Texas, where in 2009 the Central Health Board of Travis County renewed a contract to make local funding for abortion available.⁸ Seeking local funding may not work in many municipalities, but in some regions this strategy may be more promising than pursuing funding for abortion at the state-Medicaid level.

When asked for strategies to improve the Medicaid funding system in Illinois, providers often suggested a two-pronged strategy. The majority said that in order to meet the needs of their patients, Medicaid should do in practice what is required of it by court order: provide coverage for all medically necessary abortions, not just those related to rape, incest, or life endangerment of the woman. As one provider explained, "I feel it [abortion] should be covered as part of a whole range of women's reproductive health care. It's not only fair, but it makes sense." The second commonly mentioned strategy was to increase the current reimbursement rate for abortion. Most providers voiced concern about their capacity to sustain providing care with Medicaid at its current reimbursement rate. As one provider said, "It [abortion] should be reimbursed in a way that makes people want to serve the underserved." It is clear that the compensation from Medicaid for abortion services needs to be increased to make applying for funding "worth it" for providers.

We also suggest that additional activities are needed to improve access to funding for abortion care in Illinois. The confusion about the circumstances under which abortion should be covered by Medicaid indicates a need to educate both health care providers and Medicaid personnel about the funding that the law requires be available for abortion for women on Medicaid. In addition, our findings, combined with those from BWRJ, indicate that any activities aimed at increasing provider participation in Medicaid programs in Illinois would need to address challenges for providers not only with enrolling in the program, but also in receiving clear communications from Medicaid, and navigating the claims process. Efforts like these in other states, though often uphill battles, have

helped mitigate some of the challenges in accessing public funding for abortion care.⁵ The current laws about public funding in Illinois may increase the chances of successfully improving women's access to Medicaid coverage of abortion. Medicaid must be held accountable for funding abortion in the circumstances outlined by court order and federal law. Continued efforts to expand public funding for women are needed to ensure equitable access to abortion services for all women in the United States.



Ibis Reproductive Health aims to improve women's reproductive autonomy, choices, and health worldwide.

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