Ibis Reproductive Health

State-Level Research Brief

Public Funding for Abortion in Oregon

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 Oregon) currently do. Since 1984, Oregon has been under court order to provide state Medicaid funds to cover medically necessary abortions. According to reports from the Guttmacher Institute, state funds were used to cover over 4,000 abortions in Oregon in 2006, a number which has remained relatively steady over the last 20 years.[1]

Abortion care, as well as prenatal care, is covered by the Oregon Health Plan (OHP), which was developed in 1994 with the aim of expanding access to health insurance for Oregonians. With the implementation of OHP came major reforms to Oregon's Medicaid policies regarding eligibility screening and enrollment procedures, covered benefits, service delivery, and payment to health care providers for rendered services.[2] To help curb growing health care costs, a lottery system was implemented in 2008 in which individuals in need of insurance are placed on OHP's reservation list and then randomly selected to apply for OHP coverage.[3] Low-income, pregnant women are largely exempt from the lottery system because OHP has a program, OHP Plus, that fast-tracks pregnant women (among others, such as children, the disabled, or the elderly) into the Medicaid system, meaning that eligible pregnant women should be able to obtain timely access to abortion and prenatal care.[4]

Study Description

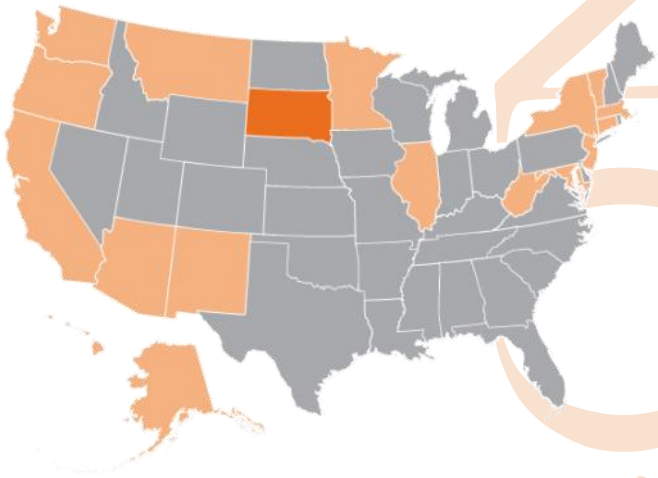
Ibis Reproductive Health has conducted a number of studies about public funding for abortion, two of which investigate in depth what is happening on the ground in Oregon.

First, from 2007 to 2010, we conducted in-depth telephone interviews with abortion providers at 70 facilities in 15 states (Arizona, Florida, Idaho, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, New York, Oregon, Pennsylvania, Rhode Island, Wisconsin, and Wyoming) and asked providers about their experiences seeking Medicaid reimbursement for abortion in circumstances of rape, incest, and life endangerment.[5,6] Because all of the Medicaid programs in the 15 states represented in the study indicate that they cover abortion in circumstances of rape, incest, and life endangerment, focusing on these cases allows for comparisons of Medicaid functioning across states.

In Oregon, we conducted five interviews with providers. Interviewees worked in facilities that provided an average of 1,535 abortions annually (range 478-3,000). Four providers worked in abortion clinics and one worked in a non-specialized health care facility. Participants had an average of 13 years of experience. Three participants were clinic administrators and two participants held multiple roles.

Next, we interviewed low-income women about their experiences obtaining and paying for abortion. Between 2010 and 2011, we conducted 71 in-depth telephone interviews with women in four states (Arizona, Florida, New York, and Oregon).

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.

We conducted 15 interviews with low-income women who had obtained an abortion in Oregon in the last five years. All participants were non-Hispanic White and an average of 28 years old. Most were single and had less than a college education; only two held full-time jobs. Forty percent of participants were mothers; these women had between one and four children. Women reported having between one to three abortions; almost all of their most recent abortions were surgical procedures obtained during the first-trimester, though four were obtained during the second-trimester.

Findings

Both women and providers described a Medicaid system that largely meets the abortion care needs of women eligible for OHP. In fact, participants reported that most eligible and uninsured women are able to enroll in the insurance program and obtain timely abortion care. However, we also found that women's lack of knowledge about the availability of abortion coverage under OHP is a barrier to accessing care and that abortion providers play a key role in educating women about the availability of coverage. Providers reported the electronic claims process, combined with knowledgeable and helpful OHP staff, make for a streamlined and user-friendly billing process for abortion care. It was also reported that immigrants, minors, and women from out of state continue to need support paying for abortion care.

Finding 1: Most eligible women are able to enroll in OHP to obtain timely abortion care

Most women and providers reported that the straightforward application and enrollment process for OHP facilitated timely access to abortion services. Indeed, among women who enrolled in OHP at the time of their pregnancy in order to obtain abortion care, the majority stated that the application process was easy to navigate. One woman said, "It was pretty simple…. I went in and filled out the paperwork and it was done." Another woman explained that she was able to quickly enroll in OHP and obtain her abortion: "When you're terminating, they expedite the process 'cause they know it's very time sensitive…. I only had to have a telephone interview, and then provide the proof of pregnancy to the worker, and that's it."

Providers expressed conflicting opinions about whether women should disclose plans to terminate a pregnancy to OHP staff in order to speed up the enrollment process. Most providers reported that OHP does not require disclosure about pregnancy plans during enrollment, which facilitates coverage. In fact, OHP enrollment procedures are the same for all pregnant women, regardless of whether a pregnancy will be carried to term or not, or the reason for a termination. One provider explained, "They cover abortions in general…. If you qualify for OHP, you get it, and that includes abortion coverage." The same provider went on to explain that the expedited and uniform application procedures are beneficial to pregnant women even if they have not decided the outcome of the pregnancy: "They don't need to have made their decision about what they are doing about their pregnancy or share that information when they are signing up [for OHP]. They can just sign up and then whatever kind of pregnancy care they need or decide on is covered for them." However, to ensure rapid enrollment, a minority of providers recommended women should disclose to OHP their desire to terminate the pregnancy.

Some women were asked about their pregnancy plans when they enrolled in OHP and had positive experiences with disclosure. One woman said, "When you go in to sign up, they ask you if you're continuing or terminating. I just asked them, 'What if I was terminating?' and they just told me it covered that too." A small number of women were afraid of being denied coverage and did not disclose that they intended to terminate. While they still received OHP coverage, they described the application process as stressful since they did not know how OHP staff would react to their plans or if they would obtain coverage.

For a minority of women, enrollment was not an easy process. One provider explained that some women face considerable difficulties enrolling in OHP and that for women without access to birth certificates, transportation, or a phone it can be arduous to wade through the process. These challenges were described in our interviews with women; two reported that the documentation required to enroll in OHP presented barriers to accessing OHP coverage. One woman explained that when she was 13 weeks pregnant she tried to enroll in OHP, but did not have a required birth

certificate. Afraid that finding the documentation would cause a delay in obtaining care, she obtained partial support from an abortion fund, and struggled to come up with the remaining costs for the procedure. Another woman was homeless and constantly moving between shelters. She said that she had to resubmit her OHP application whenever she moved, which produced gaps in her coverage.

Finding 2: Few women are aware of the availability of abortion coverage under OHP

None of the women we interviewed were aware of the availability of public funding for abortion in Oregon prior to seeking abortion care. Those who did not receive OHP coverage and used a combination of personal funds, loans from family or friends, and grants from abortion providers or abortion funds reported paying significant out-of-pocket costs that greatly impacted their lives. One woman who learned of the availability of coverage after her abortion explained, "I paid out of my pocket because I wasn't aware that they [OHP] would do that [cover abortion], so I think in all I spent like $1,000." Another woman relied on her mother for financial support for the abortion. She explained, "That was basically all her money and she was completely broke after that and it was hard for her to get by…. It didn't just affect me, it affected her, and I have a little brother that we're living with too…. They felt the impact of not having as many groceries and the necessities that went with that."

> ***"I paid out of my pocket because I wasn't aware that OHP would cover abortion, so I think in all I spent like $1,000."***

Finding 3: Providers play a key role in educating women about OHP enrollment and benefits

Providers play an active role in helping women learn about and navigate the OHP application and enrollment process. As one provider explained, "We can do the paperwork. We know exactly where to refer them. We do free pregnancy tests and in order to sign up for OHP, you just need proof of pregnancy and some proof of income. So we can give them the test and we fill that out. They can then go down to the office and we tell them where to go." This participant, and others, said they can usually help someone get enrolled in OHP within a week.

Education about the availability of OHP coverage for abortion and assistance with enrollment appeared to be particularly important for women who had never been insured by OHP. Several women, who received OHP for the first time to obtain their abortions, learned that coverage was available through their providers. One woman said, "When I made the appointment I didn't think it was gonna be covered and then they [the clinic] told me it was covered."

For some women, learning from providers that OHP would cover their abortion costs was life changing. One woman explained how important it was for her to be able to quickly enroll and obtain the covered procedure after a provider informed her of the availability of OHP coverage: "There would've been no way I could've paid for it. I probably would've had to have the child and I don't know what I would have done 'cause…I didn't have at the time, and I still don't have, any income or my own place or anything."

Finding 4: Providers are able to successfully navigate the OHP billing process

Most providers described a Medicaid program that was relatively well-functioning due to electronic and simplified billing procedures, and responsive and helpful OHP staff. This system enabled providers to receive reimbursement for provided care; providers estimated that 96% of the claims that they submitted to Medicaid in the previous year for abortion in cases of rape, incest, and life endangerment were successfully reimbursed by Medicaid.

Many of the providers reported using an online database to verify a woman's OHP status prior to providing care that helped reduce the amount of time a woman has to wait to receive care: "A lot of people haven't even gotten their [OHP] card by the time they come in, which makes the online database *really* helpful because then we can verify directly with OHP that yes they are covered, and it includes today, and here is the level of coverage."

The electronic processing of claims also helped cut down on the time providers spent working with claims as the system was efficient, user friendly, and reduced the chance for error on the part of the provider or of OHP. Most providers said the electronic system also helped ensure that they receive reimbursement in a timely manner and few could think of any cases where they did not receive reimbursement. As one provider said, "Most of the time we are very certain that the patient has that coverage and that they [OHP] will cover the visit. I don't think [any cases get denied] because we rely on that database very heavily."

Another factor that facilitated providers' positive experiences working with OHP was a simplification of the claims process when working with managed care organizations (MCOs). Prior to the development of OHP, providers reported they had to develop subcontracts with multiple MCOs, which increased the complexity of the claims process. One provider explained how now that providers only have to submit claims directly to OHP, the process has improved: "We had to have contracts with each individual health plan and there were about a dozen and some would cover abortions and some were not…. That was a real hassle…but that got changed by the state…and so that has become much easier for the patient, and for us."

> ***"In Oregon, the attempt is to provide the best medical care for the patient and not make decisions for the patient…. Allowing the patient and the doctor to handle medical care and not…the state insurance company is a good thing…. Oregon has done a very good job of that."***

For many of the providers in the study, OHP employees were instrumental to helping abortion providers navigate the OHP system when they did face billing challenges. Providers reported that OHP staff members were friendly and able to assist providers seeking help. One provider, who also had experience working with Washington Medicaid, was impressed with the support from OHP employees: "I have not had a Washington Medicaid person that I've called who has said, 'Well now, if you bill this way, this would really work well.' Whereas in Oregon, there is such a person who is really an expert in the billing for what the state desires and needs." Other providers were fortunate to have worked with the same OHP employees over a long period of time and had formed strong relationships. One provider reported, "Over our history of being an abortion provider, we've established a really good relationship with them…. We can contact our reps when we need to. It's been the same person for the past 10 years. That continuity really helps."

Additional resources that helped providers navigate the billing process were annual trainings about billing procedures and written resources provided by OHP to guide providers through the claims process.

Finding 5: Providers and abortion funds play a critical role in mediating the cost of abortion for immigrants, minors, and women from out of state

Providers reported that OHP does not meet the needs of two populations – immigrants and minors. Providers explained that in most cases immigrants who are not US citizens are ineligible for OHP abortion coverage, and that documentation required for OHP can be a hindrance to minors who do not want their parents to know that they are pregnant or seeking abortion care. Regarding minors, one provider explained: "If you are a teen living with your family, you would need to report your family income and you would need to provide documentation of that and then you would be receiving your insurance card and any correspondence from them at home. So you would have to get mom and dad's paycheck stub and then hope they somehow didn't pick up their mail…. It's a really awkward situation so sometimes with the teenagers they skip that piece of the process and go to the non-government funding instead."

Providers in the state also cared for a number of women from outside of Oregon. On average, providers said approximately 7% of women came from surrounding areas such as Washington, Idaho, and Vancouver. Many providers were contracted with Washington Medicaid, though they reported the billing process was more complex and the reimbursement rates lower compared to Oregon. Additionally, providers said women from Idaho and Vancouver often paid out of pocket and tried to obtain support from abortion funds.

All of the providers described having strong relationships with abortion funds to help provide financial assistance to women in need. On average, providers reported that approximately 10% of their clients utilize abortion funds. One provider stated, "Thank goodness we have some private funding entities…for patients who don't have the means and don't

have insurance and are not able to get insurance." One woman received support from both the clinic where she received her abortion and local abortion funds and said she felt "lucky" to get the help. However, the participant still had to pay $150 out of pocket and reported paying bills late and cutting back on food to come up with the remaining costs.

Summary

These findings suggest that the current public funding system for abortion care meets the needs of many low-income women in Oregon. Women and providers reported that the well-functioning system helped ensure timely access to care for women and presented few service delivery challenges for providers. Women reported they felt thankful for living in a state that provided abortion coverage. One woman said, "We're fortunate enough to live in a state where you do have that choice…because some states' insurances don't cover that. And then you're really left on your own." Similarly, providers reported feeling "lucky" they were in Oregon; one expressed that the Medicaid system there was "better than any other state," and another said she had to "remember how incredibly difficult that is in other states."

Women's and providers' positive experiences with OHP were unique among study states. In fact, women and providers in Oregon reported more success working with Medicaid and expressed more positive opinions about Medicaid than participants from all other states in the study.

Uniform and speedy enrollment procedures for pregnant women, regardless of their pregnancy plans, helped ensure timely abortion access. Also, streamlined electronic OHP eligibility checking and billing procedures, as well as helpful OHP staff appeared to facilitate providing abortion care, and access to it. By serving as a liaison between women and OHP, providers helped expedite enrollment and prevent delays in receiving care.

However, providers' strong relationship with abortion funds, in a state where public funding is available for abortion, illuminates that OHP does not meet the needs of all low-income women. In particular, women who are not eligible for OHP, including immigrants and women from out of state, as well as minors and women who have difficulty navigating the enrollment process, face barriers accessing and paying for abortion care in Oregon. It can also be assumed that both women with and without OHP face challenges paying for the considerable indirect costs that can be associated with abortion care, such as transportation to a clinic, lodging if an overnight stay is needed, childcare, or missed work, though these issues were not raised by women in this study.

Additionally, though many providers reported that OHP has done a great job ensuring access to care for pregnant women, they expressed concerns about the ability of the program to comprehensively meet women's whole health needs. In fact, when women are not pregnant they may face barriers getting enrolled because they have to go through the lottery system. Of the lottery, one provider said: "It seems like this lottery thing has provided some barriers to people…. I've seen definitely some change in the application process and a limit on how many people they are accepting."

It should be noted that because we interviewed only a sample of the 29 abortion providers working in Oregon,[7] the experiences of all providers may not be represented in these findings. Also, the results of our interviews with women likely do not represent the experiences of all low-income women seeking abortions in Oregon. However, our data provides a starting point for understanding the on-the-ground experiences of low-income women and abortion providers in Oregon.

We were only able to identify one other study about abortion coverage under OHP in Oregon. A mixed-methods study of women's experiences obtaining abortion care in Western Oregon found that though many women were able to readily obtain OHP coverage for abortion care, challenges obtaining coverage remain for some women, particularly for the very poor and immigrants.[8] The similar findings of our studies and the study focused on women in Western Oregon suggest a need to advocate for improved access to public funding for abortion for some populations throughout Oregon.

Next Steps

Lessons learned about the successes and remaining challenges of accessing OHP coverage for abortion can provide important feedback about ways to improve access to abortion coverage for low-income women in Oregon and can help advocates in other states develop strategies to improve access to abortion care. Our results suggest three priority next steps to improve abortion access in Oregon:

1) Educate women about OHP coverage of abortion;
2) Streamline the OHP enrollment and application process; and
3) Expand OHP eligibility requirements.

Though women eligible for OHP seem to be able to readily access coverage for abortion once they learn about its availability, challenges remain in making sure enrollment in OHP goes smoothly for all women, and that women know about the availability of coverage for abortion. Because of the respective education and enrollment efforts of abortion providers and OHP staff, many women in our study were able to quickly enroll in the public health insurance program and obtain timely abortion care. However, it can be surmised that some women who desire an abortion, particularly those ineligible for OHP or unaware of OHP coverage for abortion, never make it to an abortion provider to learn about the availability of insurance coverage, or other sources of financial support. To address these challenges, women and providers suggested a number of ways in which access to information about OHP and abortion coverage could be improved.

Many women suggested that there should be more education surrounding OHP coverage for abortion. One woman stated, "I think it would have been helpful, I think some people don't *know* that they can do this. So maybe some sort of outreach campaign." Other participants also stressed the importance of wide distribution of information about abortion coverage and even suggested making sure that information was available in schools.

> ***"We're fortunate enough to live in a state where you do have that choice… because some states' insurances don't cover abortion. And then you're really left on your own."***

A common recommendation from providers was to expand the eligibility requirements for obtaining OHP abortion coverage to include immigrants. Of the need to expand coverage to immigrants, one provider said, "I would like to see them extend their eligibility and for them to provide emergency coverage for immigrants. We have a lot of Hispanic non-citizens on OHP. They will cover labor and delivery for them, but they won't cover an abortion."

Providers also recommended undertaking efforts to ensure that women could obtain insurance even when they were not pregnant. Though providers were appreciative that eligible pregnant women were able to enroll in OHP and obtain abortion care, they worried that the insurance coverage was provided too late: "People really need to have health care before they are faced with a pregnancy… so, we really need to be at a place where people have health insurance coverage, and aren't trying to obtain it for a specific reason. You should have it before you are needing it right now."

There also appears to be a need for more education and outreach about OHP for pregnant women in need of abortion or prenatal care. Simplified and speedy application and enrollment procedures may help mitigate some barriers to obtaining OHP coverage for abortion.

Despite some remaining challenges, the Oregon system provides a model for abortion coverage in other states. One provider explained, "In Oregon, the attempt is to provide the best medical care for the patient and not make decisions for the patient…. Allowing the patient and the doctor to handle medical care and not…the state insurance company is a good thing…. Oregon has done a very good job of that."

One of the most readily replicable aspects of the system in Oregon is the use of streamlined billing procedures which are facilitated by electronic billing. It has been suggested that the use of simple or uniform claims procedures and electronic billing could decrease time spent billing and improve success receiving reimbursement in multiple health care settings.[9]

Perhaps more difficult to replicate are the sustained and positive working relationships between abortion providers and OHP staff. We have documented the importance of building and maintaining relationships with key Medicaid staff to facilitate reimbursement for abortion care in other states, and suggest that further research is needed into the training and evaluation of Medicaid staff to determine why staff in some states are better equipped than those in other states to provide billing support.[6]

Policies that stipulate states' funds can be utilized for Medicaid coverage of abortion are essential to ensuring low-income women can obtain timely access to abortion services. However, expansive policies alone are insufficient to ensure all women can obtain coverage for abortion care as some of the most disenfranchised are ineligible for public insurance, and other barriers to accessing abortion care exist. Continued efforts to expand and protect public funding for low-income women are needed to ensure equitable access to abortion services for all women in the US.

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Ibis Reproductive Health

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