Ibis Reproductive Health

Impacts of funding restrictions on abortion access: Tennessee

Medicaid, abortion, and the Hyde Amendment

Medicaid is a joint federal and state health insurance program in the United States for people who meet income eligibility criteria, i.e. households with incomes up to 138% of the federal poverty level.[1] Medicaid coverage has been shown to improve health outcomes and reduce mortality; however, coverage varies state-to-state and restrictions on coverage have a disproportionate impact on those with limited financial means.[2]

Women comprise over two-thirds of adult Medicaid enrollees, and approximately 67% of women on Medicaid are of reproductive age (15-44 years).[3,4] Although Medicaid covers a wide range of reproductive health care services, including family planning, prenatal and postpartum care, and childbirth, coverage of abortion services is limited by the Hyde Amendment.

First passed in 1976, the Hyde Amendment prohibits federal funding for Medicaid coverage of abortion care except when a person's* pregnancy results from rape or incest, or when it endangers the pregnant person's life.[5] The Hyde Amendment has been renewed annually as a rider to the Labor, Health and Human Services, Education, and related Agencies (Labor-H) appropriations legislation.[6] States may elect to use their own funds to cover abortion care for pregnant people with Medicaid under broader circumstances; however, as of January 2020, only 16 states have opted to use their own state funds to cover abortion in most cases, while 34 states and the District of Columbia follow the federal Hyde prohibitions.[7]

In 2014, three-fourths of all women who had an abortion in the United States were low income, one-half of whom were living under the federal poverty line and eligible for Medicaid coverage.[8]

**In this brief we use the gender-inclusive term "pregnant people" (versus "pregnant women") in recognition of the fact that people of many genders, including transgender men, non-binary people, and those of additional gender identities beyond cisgender women experience pregnancy and abortion. When citing other research, we default to terminology used by those study authors.*

Yet Medicaid accounted for just 24% of payments for abortion care that year, with many patients having to pay out-of-pocket.[8] Research in a similarly restrictive Southern state found that Medicaid funding restrictions may lead to 29% of pregnant women who meet criteria for Medicaid continuing a pregnancy rather than obtaining an abortion.[9] For pregnant people who are able to obtain an abortion, these funding restrictions may delay wanted care or force them to forgo needed household expenses, such as groceries or rent, in order to pay out-of-pocket for care.[10]

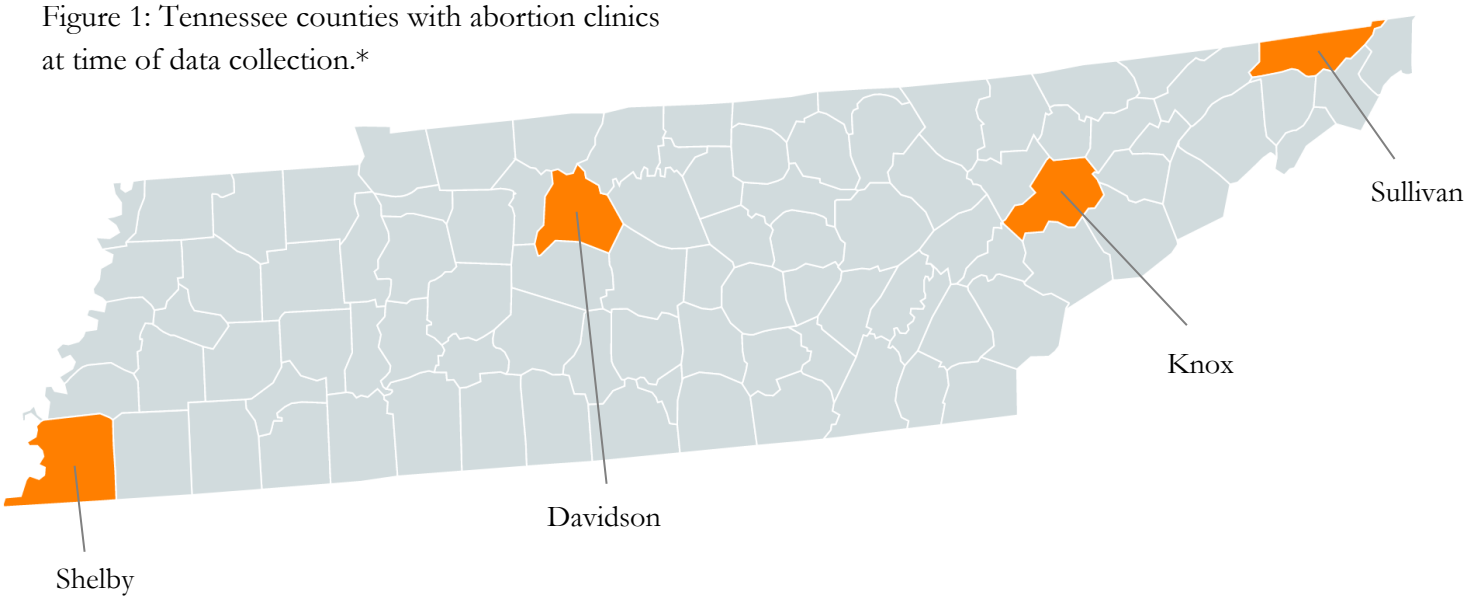
Abortion landscape in Tennessee

In 2017, approximately 12,140 abortions were provided in Tennessee, both for in-state and out-of-state residents.[11] At that time, 63% of Tennessee women lived in a county without an abortion provider.[11] Tennessee is among the states that impose additional requirements on people seeking abortion services, including in-person counseling and a 48-hour waiting period, which force patients to visit the same medical doctor twice; the state does not allow counseling to be provided by non-physicians.[13] The state also prohibits the use of telemedicine for medication abortion by requiring all abortions be performed in the physical presence of a physician.[13] These restrictions place an unnecessary burden on patients, especially those who live in areas without a provider, who must take additional time off from work, family, and other obligations, and incur higher costs due to travel, missed work days, and often child care.[15]

In addition to restricting public funding of abortion coverage through TennCare, Tennessee's Medicaid program, to cases of life endangerment, rape, or incest,[13] Tennessee was one of several states to prohibit insurers that participate in the Affordable Care Act health care exchange from offering plans that include abortion coverage.[12] In 2018, 20% of women in Tennessee were covered by TennCare and thus potentially impacted by this restriction.[14]

Evidence of how Medicaid abortion coverage policies are implemented and what influence they have on service delivery is limited. In order to determine the impact of these restrictions on abortion patients and providers, we investigated abortion providers' experiences securing Medicaid, Medicare, and private insurance reimbursement for abortion care in the state of Tennessee.

Figure 1: Tennessee counties with abortion clinics at time of data collection.*



Methods

We interviewed abortion providers from clinics in Tennessee between September 2017 and July 2018. During this time, the Hyde Amendment and Tennessee's policies regarding Medicaid coverage of abortion remained in effect. Interviews primarily consisted of open-ended questions about providers' experiences seeking Medicaid coverage of abortion in cases of rape, incest, and life endangerment of the pregnant person, as well as any experiences obtaining Medicare or private insurance coverage for similar cases. We also asked providers to describe the circumstances of these cases, the services provided, and the process and outcome of seeking insurance coverage, including in cases where a pregnancy resulted from rape, incest, or endangered the life of the pregnant person. The Allendale Investigational Review approved this study. Participants are identified by their years of involvement in abortion care.

Findings

Provider and clinic information

Provider experience both in abortion care and at their current clinic ranged from less than a year to 11 years. Providers worked at clinics across the state and most offered both first- and second-trimester care. Across all clinics, the minimum and maximum gestational age limits ranged from four weeks to an upper limit of 19 weeks. The average cost of a medication abortion was $635. Costs for a first-trimester surgical abortion averaged $680, and in the second trimester, $927. Providers also noted that a number of their patients travelled from out of state to obtain abortion care; the proportion of out-of-state patients ranged from eight percent to 35% across clinics. Out-of-state patients reportedly travel to Tennessee from states including Kentucky, Mississippi, Arkansas, Missouri, Alabama, Virginia, North Carolina, and Georgia.

None of the providers that we interviewed had personal experience handling a case for a patient with Medicare insurance. Abortion providers experienced in caring for pregnant people with Medicaid private insurance highlighted the ways in which funding restrictions impact patient access as well as provider delivery of abortion care. Among the themes raised by providers, we observe three primary challenges that impact patient access to and experiences of abortion care in Tennessee, including administrative requirements that prevent providers from accepting TennCare, high cost burdens for both patients and providers, and reimbursement processes that delay payment.

Administrative processes can deter clinics from accepting insurance for abortion care

Long, complicated, and cost-prohibitive credentialing processes, as well as the variability of insurance credentialing across individual providers at the same clinic site, were cited as barriers for accepting forms of both private insurance and TennCare. For some clinics, this resulted in them no longer accepting TennCare or specific private insurers for any type of care. One provider noted,

* *Subsequent to data collection, an additional clinic began operating in Wilson County.*

> …you would think that like if it's in the same state and it's Medicaid policy that it would just be clear cut and dry what you need – just a checklist, like this is what you need to do to fulfill these requirements for reimbursement. But it just seems like each person that you talk to has a different requirement that they're going to tell you that you need and it never seems to be enough. You never seem to have what you need to have to get the person coverage.
>
> *Participant C, nine months experience*

The same provider characterized private plans as "always easier. And they're more likely to cover [abortion care]. If you don't have a private plan, then it's probably not covered."

In addition, patient and provider scheduling needs, as well as the variety of insurers managing private insurance and Medicaid plans, can make it unfeasible to match providers credentialed with specific insurers to patients covered by the corresponding insurer at every appointment. As one provider described, "it depends on which doctor [the patients] go to and which insurance the doctor takes." (Participant A, one year experience)

Patients, abortion funds, and clinics are absorbing the cost of procedures that should be eligible under Medicaid

For those patients eligible to use TennCare for their abortion, providers reported having to assist them in seeking funding independently, from abortion funds or through in-clinic funds, because obtaining a police report to prove rape or incest could be complex or traumatizing. They also highlighted that some patients may feel uncomfortable disclosing the circumstances of their pregnancy or pursuing legal action, and may prefer to keep such details private even when disclosing would result in the cost of the procedure being completely covered by Medicaid. One provider described the discomfort that patients have shared with them, stating,

> So there's no reasonable way that someone could prove that they were raped in time to have their abortion paid for. And plus I think it's kind of sick to say they have to prove that because most of the patients that I see that are pregnant as a result of rape, I ask them if they're pressing charges because then we would need to work with the police to collect DNA. And most of them are like I'm afraid that the police – I don't wanna deal with the police, I just want this to be over [with]. And also having a rape kit done is expensive and it's time-consuming and it's very traumatic to have to go through that.
>
> *Participant A, one year experience*

Medicaid reimbursement for eligible abortions is inadequate or delayed

Reimbursement for cases eligible for TennCare coverage was also inadequate, with providers reporting that it was not unusual to submit Medicaid claims multiple times. They reported that claims would be rejected for various reasons. Even when claims were eventually approved, the prolonged wait for reimbursement could require the clinic to absorb costs in the interim and to expend additional staff time in order to repeatedly follow up in pursuit of reimbursement. When asked if the clinic has to absorb the cost not paid by insurance or the patients, one provider noted, "We can send [patients] a bill all they want, but if they don't have it, they don't have it. So yeah, we don't really have a choice but to absorb that cost." (Participant C, nine months experience)

Recommendations

1. Streamline the administrative requirements for clinics to maintain TennCare-provider status

Removing difficult and cost-prohibitive requirements can make accepting TennCare insurance more sustainable for providers by allocating staff time spent on administrative processes elsewhere. If the process for accepting TennCare were streamlined, patients could use TennCare coverage for all medical services at abortion clinics thereby supporting continuity of care and potentially increasing the number of patients able to obtain wanted care at abortion clinics. Ultimately, improving administrative processes can support patients with limited financial means in accessing the care they need with the coverage they already have.

2. Provide clear guidance about requirements for TennCare reimbursement claims

Providing a clear set of reimbursement requirements for clinics will ensure that all necessary paperwork and forms are submitted correctly the first time, thus reducing delays in reimbursement. This will ensure that clinics will be reimbursed quickly without the use of unnecessary administrative time and resources such as having to submit the same claim multiple times. Ensuring that reimbursement processes are clearly and consistently communicated will support clinic financial sustainability in an environment where there are already a limited number of clinics operating in the state.

3. Expand TennCare coverage of abortion to all pregnancies regardless of circumstance

Patients should not have to provide evidence or justify their decisions about abortion. TennCare should cover all abortions, not just those that are a product of rape, incest, or that endanger the life of the pregnant person, in order to improve access for patients with limited means. Such funding restrictions may prevent people from obtaining a wanted abortion and instead force them to carry an unwanted pregnancy to term.[9]

> "I think abortions are kind of on the back burner with a lot of things that people are not able to afford. Some people that have no jobs or living on fixed incomes. And I think they're having a really, really hard time, and no fault of their own…"
>
> *Participant D, ten years experience*

Removing the requirements to prove eligibility will also reduce confusion about who can access abortion care and expand overall access in the state. Individuals should have a clear understanding of their coverage under TennCare, including coverage of abortion care. Improving awareness around TennCare coverage will ensure access for those who need an abortion and provide clarity about their financial options, thus reducing delays in wanted care.

> "[P]robably for every one patient seen in a clinic facility, there's like five or six more people that are interested in accessing abortion care or want to access abortion care, but it's just such a daunting amount of hoops to jump through [to access care] that they're unable to do it. Even with an organization who's like, hey, we'll come get you, we'll put you up, we'll sort out childcare – it's just so much that I think we're probably seeing maybe like a fifth or less of the actual people who have felt like, oh, I want an abortion in Tennessee or I think that I want an abortion in Tennessee."
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> *Participant B, seven years experience*

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