



State-Level Research Brief

Public Funding for Abortion in New York

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 of using state funds to cover abortion in broader circumstances, but only 17 currently do.¹

Since 1970, New York has voluntarily used state Medicaid funds to cover abortion.¹ The state has several public insurance programs that cover abortion, all falling under the umbrella of Medicaid. Additionally, women who are eligible, but not enrolled in one of New York’s public insurance programs can be considered presumptively eligible for Medicaid and quickly and temporarily enrolled in the program to cover the cost of abortion. Most counselors at a health care clinic can help arrange this coverage.² Further, the National Institute for Reproductive Health and NARAL Pro-Choice New York have created state-level guides for women and abortion providers about how to obtain Medicaid coverage for abortion in New York.²⁻³

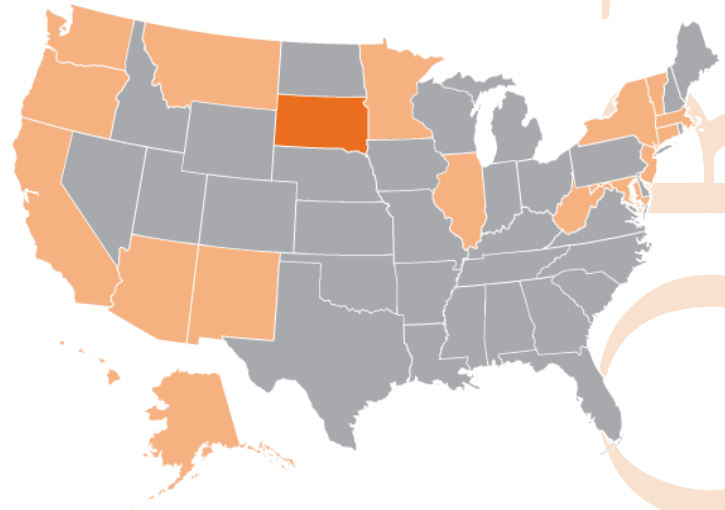
STUDY DESCRIPTION

Ibis Reproductive Health has conducted a number of studies about public funding for abortion,⁴⁻⁸ two of which investigate what is happening on the ground in New York.

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 coverage for abortion care in cases of rape, incest, or life endangerment. Because all 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.

Next, we interviewed low-income women about their abortion care experiences. Between 2010 and 2011, we conducted over 70 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.

In New York, we conducted five interviews with abortion providers, most of whom were located within New York City. Participants had an average of 15 years of experience in the field. Four participants were clinic administrators and one participant was a nurse. Interviewees worked in facilities that provided an average of 1,104 abortions annually. Two participants worked in abortion clinics, two worked in non-specialized health care facilities, and one worked in a hospital.

We conducted 20 interviews with low-income women in New York, most of whom obtained abortions in New York City. Participants were on average 29 years of age and most had at least some college education. Twelve women self-identified as White, two as Black, one as Asian, one as Native American, and the remaining four women as multi-racial or another race. Women of multiple ethnicities were represented with Latina being the most common and reported by five women. Most women reported they had first-trimester surgical procedures.

FINDINGS

Both women and providers described a Medicaid system that largely meets the abortion care needs of women in New York. Participants reported that most Medicaid enrollees are able to obtain timely abortion care and that presumptive eligibility policies increase women's access to affordable abortion care. However, barriers to abortion care remain for some women. Also, though most providers reported success navigating the Medicaid billing system, they also said that some administrative challenges remain.

Finding 1: Women enrolled in Medicaid are able to afford abortion care, though some barriers to abortion remain

Half of the women interviewed used Medicaid to cover their procedures and reported no out-of-pocket costs.

The remaining participants paid out of pocket (25%), or used private insurance (20%) or Medicare (5%). Women insured by Medicaid reported being able to access abortion coverage information and benefits. They were also aware that some clinics did not accept Medicaid and therefore they sought out clinics that did. One woman recalled, "I remember going to one clinic and they were talking about [charging] maybe \$200-\$300 because they didn't accept my health insurance...so I went somewhere else and I had full coverage.... It was easy.... I was relieved." Similarly, almost all of the abortion providers reported that the existence of broad Medicaid coverage helped make abortion accessible.

Only a minority of women and providers reported that some women face challenges learning about and obtaining abortion coverage. In particular, women and providers reported that women enrolling in Medicaid for the first time or generally unfamiliar with the public health system in New York had difficulties navigating Medicaid and securing abortion coverage. These challenges led to delays in obtaining care while women searched for alternative resources to pay for their abortions. Also, some providers reported that women who did not qualify for Medicaid, but struggled to make ends meet, had difficulties affording abortion care. One provider explained, "I think that if you are eligible for Medicaid in our



state...you are fine; you get everything covered. If you are not eligible for Medicaid...and you aren't wealthy enough to buy health insurance, those are the women who end up getting screwed...in terms of abortion coverage."

Finding 2: Presumptive eligibility policies help ensure access to timely, affordable abortion care

Pregnant women without insurance can obtain immediate coverage for their abortion if deemed by a qualified health care provider to be presumptively eligible for Medicaid.³ Women reported that presumptive eligibility made obtaining what many referred to as "Emergency Medicaid" for abortion care much easier than going through the standard process of enrolling in Medicaid to obtain benefits. One woman explained that after being quickly determined presumptively eligible for Medicaid, she was able to get the care she needed:

"I know some people did have to scrape every last dollar they had to pay for it [abortion], but I was lucky enough that they gave me the Emergency Medicaid." Another woman explained how Emergency Medicaid helped ensure she could obtain timely care. She said, "I think it [the abortion] was like either \$400 or \$450 and I remember feeling like 'Ok, I'm going to have to wait a few more [weeks]...because I have to wait to get the money to do it.'" Fortunately, the participant was presumptively eligible for Medicaid and was able to avoid the anticipated delays.

Like women, providers reported that presumptive eligibility policies helped their clients avoid delays receiving care. As one provider said, "The presumptive eligibility thing has made accessing Medicaid for women a lot easier." Another provider stated, "We don't make women in New York State jump through a whole lot of hoops to show eligibility."

Despite the strong evidence of success with presumptive eligibility policies, we found that not all uninsured women were able to access Emergency Medicaid. Five women in the study were uninsured at the time of their abortion and paid for care. While they were likely eligible for Emergency Medicaid, these women never learned about presumptive eligibility and did not know that Medicaid covered abortion.

Finding 3: Providers are able to successfully navigate the Medicaid billing process, though some challenges remain

Almost all providers reported that the claims process was straightforward and that they consistently received reimbursement from Medicaid for abortion. In one provider's words, "It's easy.... If we send in a clean claim, we'll get reimbursed." Additionally, the majority of providers found the processing time to be quick, receiving compensation within a few weeks after submitting claims. Many providers attributed their success to the implementation of an efficient and user-friendly electronic system for filing claims; the system helped eliminate billing errors that led to delays in reimbursement. One provider explained, "When we used to do paper claims, they would scan them and often times there would be errors and I'd have to resubmit a lot.... It's not usually an issue [now] since we have electronic billing. It's very easy with the electronic billing."

However, some providers did report challenges with the Medicaid system. The multiple managed care organizations (MCOs) available under New York Medicaid complicated billing because of the different funding requirements from each MCO. One provider explained, "What I do think is very complicated is we have all these different sub-types of Medicaid.... It doesn't make any sense to me. I don't know why it is the way it is.... That makes things very complicated for our financial people because they all have different contact people, they have different eligibility criteria, and whatnot."

Some providers also reported challenges obtaining billing support from Medicaid. Though in some circumstances providers found Medicaid staff to be knowledgeable and able to assist providers seeking help, in others, providers received inaccurate information about reimbursement rates and covered benefits. As one provider explained, "When we try to find out anything, they [Medicaid] are just squirrely. Nothing is in writing. One person will tell you one thing and then another person will tell you another."

A challenge reported consistently by providers is that Medicaid reimbursement rates are generally lower than clinic costs. Additionally, as one provider explained, reimbursement

rates from MCOs are generally lower than the state Medicaid rate: "We get \$174 for an abortion from a Medicaid managed care program, even though New York state gives us \$230. So, if you think of it that 51% of our patients are on Medicaid, that can add up to a lot of money."

SUMMARY

These findings suggest that the current public funding system for abortion meets the needs of many low-income women in New York. Women and providers reported that the well-functioning system helped ensure timely access to affordable care for women and presented few service delivery barriers for providers. In fact, women and providers in New York reported more success working with Medicaid than participants from most other study states.

It appears that the availability of multiple public insurance programs that cover abortion, uniform and speedy Medicaid enrollment procedures, the availability of presumptive eligibility, and streamlined electronic billing procedures contributed to women's and providers' positive experiences with public funding for abortion care.

However, some women's lack of familiarity with the Medicaid system and the circumstances under which Medicaid covers abortion presented barriers to care. Additionally, working with MCOs, receiving inconsistent support from Medicaid staff, and low reimbursement rates for abortion presented service delivery problems for providers. Also, though it did not emerge in our research, previous reports have noted that not all Medicaid MCOs in New York, particularly Catholic ones, cover abortion care, creating access barriers for women insured by some MCOs.³

Our findings must be viewed in light of some limitations. The results of our interviews with women likely do not represent the experiences of all low-income women seeking abortions in New York. Particularly, most of the women interviewed resided in New York City; the experiences of those living outside the city where there are fewer resources are not represented. Also, because we interviewed only a small sample of abortion providers in the state,⁹ most of whom worked in New York City, the experiences of all providers may not be represented. Regardless, our findings provide a starting point for understanding the on-the-ground experiences of low-income women and abortion providers in New York.

NEXT STEPS

Lessons learned about the many successes and remaining challenges of accessing Medicaid coverage of abortion in New York provide important feedback about the functioning of the Medicaid system. Our results suggest three priority next steps to improve and protect abortion access in New York:

1. Expand income requirements, as outlined in the Affordable Care Act, so that women who currently do not qualify for Medicaid, but are struggling to make ends meet, can access affordable abortion care.
2. Ensure all women enrolled in or eligible for Medicaid are informed about the availability of abortion coverage under most Medicaid plans to prevent delays in learning about coverage and obtaining care.
3. Increase reimbursement rates for abortion care and make them consistent across MCOs to ensure abortion providers are adequately compensated for their services.

Despite some remaining challenges, the New York system provides a model for advocates developing strategies to improve or protect access to abortion coverage in other states. In particular, advocates in other states may consider calling for presumptive eligibility and electronic billing procedures, among other strategies outlined in our Take Action guides,¹⁰ to improve access to abortion coverage for low-income women in their own states. Advocates in other states may also consider creating resources for their states, targeting both women and providers, that detail how to obtain and pay for abortion care, as has been done in New York.²⁻³

Policies that stipulate states' funds can be used for Medicaid coverage of abortion are essential to ensuring low-income women can obtain timely access to abortion. Without coverage, abortion would be unaffordable or unattainable for hundreds of thousands of women on Medicaid in New York. Additionally, continued efforts to expand public funding for low-income women are needed to ensure equitable access to abortion services for all US women.



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