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Looking Back at the Hyde Amendment and Looking Forward to Restoring Public Funding: A Research and Policy Report

by
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Introduction: Soon after abortion was legalized in the United States in 1973, abortion opponents began an aggressive push to limit women's access to the service. One of the first and most effective strategies that abortion opponents pursued was advocacy for prohibitions against the use of public funds for abortion care. Representative Henry Hyde (R-IL), proposed restricting access to abortion for low income women and, in 1976, the Congress passed what is now known as the Hyde Amendment.

The Hyde Amendment, which is renewed annually as part of the appropriations process, prohibits federal Medicaid funding for abortion except when a pregnancy results from rape or incest, or endangers a woman's life. Throughout the history of the Hyde Amendment, the "rape, incest, and life endangerment" exceptions covered by federal funds have been fiercely debated as part of the struggle between those trying to restrict abortion access and those trying to expand it.[1]

While individual states can opt to use state Medicaid funds to cover abortion under a broader range of circumstances, few currently do. In fact, 32 states and the District of Columbia follow the federal example and restrict the use of Medicaid funds for abortion to the exceptions allowed under the Hyde Amendment. Among the 32 states, Iowa, Mississippi, Utah, and Virginia extend state coverage of abortion to cases of fetal anomaly and Indiana, Utah, and Wisconsin extend abortion coverage to women when the abortion will prevent long-lasting damage to the woman's physical health. South Dakota limits access to abortion coverage beyond the confines of the Hyde Amendment; in direct violation of federal law, the state only covers abortion when a woman's life is endangered. Finally, 17 states use their own funds to pay for all or most medically necessary abortions, though most do so by court order and not voluntarily.[2]

Restrictions on Medicaid coverage affect a large number of low income women. Medicaid provides health care coverage to almost 60 million people[3] who would otherwise lack access to health insurance.[4] Women make up over two-thirds of the adult population insured by Medicaid, and nearly two-thirds of women on Medicaid are of reproductive age. With over 20 million adult women enrolled in Medicaid, the Hyde Amendment has a profound impact on the health and wellbeing of low income women and their families.[5] Most women enrolled in Medicaid are unable to utilize their health insurance for abortion coverage. This can make it nearly impossible for women to obtain abortion care because a

first-trimester abortion can cost more than half of what a family at the poverty level lives on in one month.

Restrictions on Medicaid coverage of abortion are not only an issue of reproductive health but also of reproductive justice. Abortion funding restrictions disproportionately affect poor women who, when compared to their higher income counterparts, are more likely to be women of color[6] and have poorer health.[7] Documenting the impact of the Hyde Amendment and outlining strategies to improve Medicaid coverage are critical in order to understand how abortion coverage restrictions affect women and providers and to identify strategies to improve access to timely and affordable abortion care for Medicaid-eligible women.

Research Methods: From 2007 to 2011, Ibis Reproductive Health conducted a series of studies investigating the impact of the Hyde Amendment on women and abortion providers, including: in-depth interviews with abortion providers at 70 facilities in 15 states about their experiences obtaining Medicaid reimbursement for abortion care; in-depth interviews with more than 70 low income women in four states about their experiences obtaining and paying for abortion care; a "mystery caller" survey of Medicaid staff in 17 states assessing the information staff provide to women seeking abortion coverage. The methodological details of these studies have been presented in-depth elsewhere and are summarized in brief below.[8-10]

Data collection: In the first research project, we conducted interviews with abortion providers about their experiences handling cases of rape, incest, and life endangerment, and seeking Medicaid and insurance coverage of abortion for those and other cases. Between 2007 and 2010, we conducted 68 in-depth telephone interviews with participants representing 70 facilities that provide abortion services in 15 states. These included interviews with participants in five states where policy stipulates that Medicaid funding can be used to cover all or most abortions (Arizona, Illinois, Maryland, New York, Oregon) and in 10 states with restrictions on the circumstances under which Medicaid funding can be used for abortion (Florida, Idaho, Iowa, Kansas, Kentucky, Maine, Pennsylvania, Rhode Island, Wisconsin, Wyoming).

Of the 70 facilities included in our analysis, most primarily or exclusively provided abortion services, and provided between 400 and 3,000 abortions annually. Participants interviewed had an average of 14 years experience in abortion provision, and most held an administrative role at the facility, though we also interviewed clinical support staff, counselors, financial managers, and physicians. Throughout this report we identify abortion provider participants by the type of facility they work in, their self-identified role at the facility, and the number of years they have been working in abortion care. To protect abortion providers' identities, however, we do not name the state in which they work; in some states with a small number of providers the participant could be identifiable.

In the second research project, we interviewed low income women about their experiences obtaining and paying for abortion care, as well as their knowledge and opinions of public funding for abortion. Between 2010 and 2011, we conducted 71 semi-structured, in-depth telephone interviews with low income women who obtained abortions in Arizona, Florida, New York, and Oregon. These states were selected based on our research with abortion providers as we found that these states represent best and worst case scenarios regarding Medicaid coverage of abortion. Providers reported that women in Oregon and New York were able to access coverage much more easily and frequently than women in Arizona and Florida.

Women interviewed in the second study were an average of 30 years of age (range 18-55), most were single, and had some college education. They reported between one and three abortions; almost

three-quarters were surgical procedures obtained during the first trimester. Throughout this report we identify these participants by a pseudonym, their age, and the state that they lived in at the time of their most recent abortion.

In the third research project, we used a "mystery caller" approach to evaluate whether Medicaid staff provided accurate information about the availability of and procedures for securing Medicaid coverage of abortion when a pregnancy is the result of rape or endangers the life of the woman. Over a two month period in 2010, we called Medicaid staff in the same 17 states where we had previously recruited abortion providers, and followed a script in which we asked Medicaid staff about the availability of Medicaid coverage of abortion, and the process for securing it.

Data analysis: The interviews with both the providers and the women were transcribed verbatim and coded in ATLAS.ti version 5.2 or 5.5 (Scientific Software Development, Berlin, Germany) with a combination of inductively and deductively developed codes. This allowed for a thematic analysis of answers to our original research questions, as well as an exploration of emerging themes. We then selected quotations that illustrated identified themes;we used Excel version 2007 (Microsoft Corp, Redmond, WA) to summarize demographics, key participant and facility characteristics, and responses to closed-ended questions.

To analyze data from our mystery caller of Medicaid staff, we first transcribed the content of all calls and then input all survey responses into Microsoft Excel 2007 in order to calculate summary statistics. After summarizing our key quantitative findings, we reviewed the transcripts of all calls and identified illustrative quotations that demonstrated our main findings.

All studies had IRB approval and human subjects measures in place.

Results: Findings from our three research projects provide in-depth data on the systematic barriers women face in accessing Medicaid coverage of abortion and highlight challenges for providers who work with Medicaid. Our data also highlight potential opportunities and strategies for implementing needed change. We have reported on some aspects of our findings elsewhere,[8-10] and provide synthesized findings here.

Overall, we found that many women seeking abortion in cases of rape, incest, or life endangerment do not have the option to use Medicaid for abortion coverage due to challenges enrolling in and using Medicaid to cover abortion care. Additionally, abortion providers reported that they face a number of challenges working with Medicaid. We discuss in detail below how each of the challenges contributes to undesired outcomes for women, and also creates service delivery problems for abortion providers. We then summarize recommendations from our own and others' work, highlighting ways that abortion providers, women's health advocates, and policy makers can improve access to abortion for low income women who are eligible for Medicaid.

Women Face Difficulties Enrolling in Medicaid and Accessing Abortion Benefits: Many of the women and abortion providers we interviewed described enrolling in Medicaid as an unduly arduous process that was a barrier to abortion access for women whose abortions qualified for coverage. Uninsured women faced challenges enrolling in the insurance program due to confusing eligibility requirements, complex enrollment procedures, difficulties gathering enrollment documents (such as birth certificates), and problems finding someone at Medicaid who could answer enrollment questions.

Further, the multiple managed care organizations (MCOs)[a] administering Medicaid in many states appeared to increase women's confusion about enrolling in the program. Women had limited information about the differences between MCOs and were largely unaware of how to choose a plan that would best fit their needs.

In addition to finding the enrollment process to be complex, women also reported that enrollment was or had a reputation in their communities of being incredibly time-consuming. After having applied for Medicaid, some women experienced delays accessing care due to the time it took to process their application; in several cases women received enrollment verification after they had already obtained their abortion. For others, the common perception that enrollment in Medicaid is time-consuming was enough to deter them from enrolling in Medicaid at all.

In some cases, the enrollment process was further delayed due to unanticipated expenses associated with the Medicaid application, such as costs to call or fax paperwork to the Medicaid department. These expenses were described as factors that could slow down the application process and delay women from accessing their Medicaid benefits. One woman described the financial burden of having to come up with the money to fax her enrollment documents to Medicaid:

> If you didn't have to go through so much, being hung up on after you give them [Medicaid] your documents…they ask you to fax, and in Florida, where I am, it's $4 a page to fax to a local number…. All the pages you need can come up to more than $10. No one has like $50 to just be faxing. And there's no like free fax machines (Destiny, age 27, Florida).

Women who successfully navigate the enrollment process often encounter challenges in securing Medicaid coverage of abortion. Many women are unaware of federal and state policies that determine if their Medicaid program covers abortion care. In fact, almost none of the women we interviewed had ever heard of the Hyde Amendment, and few were aware of if, and under what circumstances, their state Medicaid program covered abortion care. For women living in states where abortion coverage is available in most cases, this lack of knowledge was a major barrier to accessing Medicaid coverage of abortion, because they did not know how to access coverage or even to ask about it. For example, one Oregon woman who learned of the availability of Medicaid coverage in her state after her abortion reported that"I paid out of my pocket because I wasn't aware that they [Medicaid] would do that [cover abortion], so I think in all I spent like $1,000" (Britt, age 23).

For women who did consider Medicaid a source of coverage for abortion, the next hurdle was getting correct information about what is and is not covered by Medicaid and how to access coverage when it is available. We found that Medicaid customer service lines were a poor source of information about the availability of and process for securing abortion coverage. In our mystery caller evaluation of information provided by Medicaid staff about abortion benefits, many Medicaid staff members provided inconsistent and incorrect information about the availability of coverage, and implicitly discouraged women from seeking out coverage by suggesting that women would be unlikely to obtain it, or face great difficulties securing it.

Furthermore, in our interviews with women, we found that women living in states with Medicaid restrictions found it particularly difficult and time-consuming to reach someone at Medicaid in order to obtain accurate information about abortion coverage. One Florida woman, for example, described being on the phone for a long time and having a hard time getting through to a live person: "I really hate that it's all automated, and that you don't really talk to anybody…. If you have questions, who do you ask?

[a] Some people who enroll in Medicaid have to choose a health plan through an MCO. MCOs are health care organizations that contract with a network of providers to give services to people enrolled in Medicaid. MCOs can differ in the types of health services that they cover and the amount of providers that accept each plan.

You call a 1-800 number, and you might get through if you keep trying for a few days" (Valerie, age 23).

When unable to receive accurate information from Medicaid about abortion coverage, many women turn to their abortion providers for information about how to pay for their abortion. While providers play a key role in educating women about Medicaid benefits, many abortion providers that we interviewed reported they frequently have trouble obtaining accurate information from Medicaid about when and if Medicaid coverage is available in the state in which they provide care. One counselor with nine years of experience working at an abortion clinic in a state where most abortions should be covered by Medicaid described her own lack of knowledge about abortion coverage, and desire for more information:

[I know] very little [about Medicaid coverage for abortion in my state], unfortunately, because we don't do much around it. But, I understand that [state] does provide some monies for provision of services in certain cases. What those specific cases are, or degrees of them, I'm not sure.

Lack of knowledge and challenges obtaining accurate information about Medicaid coverage are not the only barriers women face in their attempts to access abortion benefits under Medicaid. It can also be difficult for women to find an abortion provider that accepts Medicaid at all, or accepts specific MCOs as a payment method for abortion care. This can be especially difficult for women living in states with few abortion providers. A sizeable number of providers explained that they did not accept Medicaid or specific MCOs because of multiple bureaucratic barriers that providers face (described in more depth below) which have prompted many to "give up" working with Medicaid altogether. One woman, enrolled in Medicaid and eligible for Medicaid coverage of abortion, explained the impact of going to a clinic that did not accept her plan:

The problem with Medicaid is that you have so many plans to choose from and they're all so confusing and not a lot of doctors accept certain plans…. I made the mistake of choosing it [an MCO]…and I thought it would be just as good and it wasn't. No one accepted it. (Lucia, age 25)

Many Abortion Providers Face Challenges Working with Medicaid: Abortion providers face numerous obstacles when providing women Medicaid-covered abortion care in qualifying cases. The most common challenge cited by abortion providers we interviewed was the administrative burden associated with filing claims in order to be reimbursed for care provided in cases of rape, incest, and life endangerment. Filing a Medicaid claim for abortion care was described by almost all the abortion providers we interviewed as a frustrating, complex, and paperwork-heavy process that requires excessive staff time to fulfill. Additionally, the challenges involved with filing claims have only increased with the proliferation of MCOs. One clinical support staff member with four years of experience working in a hospital explained:

What I do think is very complicated is we have all these different sub-types of Medicaid and…it doesn't make any sense to me.… Patients can sign up for different types of Medicaid…and they all have different nuances, but they're all under the umbrella of Medicaid. I don't know why and I think that makes things very complicated for our financial people because they all have different contact people, and they have different eligibility criteria and what not.

Despite the challenges of filing claims, some providers described working tirelessly to do so and in many cases had to file claims multiple times due to frequent rejections or other problems with the documentation required to fulfill claims. In fact, in 13 of the 15 states where we interviewed abortion providers, participants reported considerable difficulty working with Medicaid. On average, 64 percent of the qualifying claims submitted in the 13 states where providers had difficulty working with Medicaid

were ultimately rejected. Providers facing frequent rejections said that Medicaid frequently denies claims for unspecified reasons. One administrator, with almost three decades of experience working at an abortion clinic, described her confusion about the reasons behind her clinic's frequent rejections: "For some reason they deny coverage for a lot of those people that we bill for. I don't know…if that's just what they do…. I'm not sure of the reasons why we're not paid."

The rejected claims were those that abortion providers submitted for women seeking abortions in cases of rape, incest, or life endangerment – the so-called Hyde exceptions which federal policy mandates should be covered by Medicaid. Providers speculated that part of the reason for the rejections is due to difficulties proving to Medicaid the circumstances of women's abortions. Indeed, abortion providers reported that it is not always clear how Medicaid -- or the Legislature -- defines rape, and that women, providers, and Medicaid often have varying definitions of what constitutes rape. The challenges of verifying if a pregnancy is a result of rape were described by one abortion clinic administrator who has worked in abortion care for 15 years:

> There is…the violent, obviously rape, and then you get into the gray areas, things along the lines of at a party, date rape, and possibly consensual…. The roofies kind of fall in between the obviously rape…. You've also got some things with husbands: they're estranged, they're married, they're living separately, then he comes back and has sex with her, and - it's sticky.

Furthermore, some providers reported that Medicaid or particular MCOs require that providers submit a police report of the rape to verify to Medicaid that the rape occurred. An administrator with over 30 years of experience working in an abortion clinic explained that "the state does require a police report for the Medicaid reimbursement.… If they were Medicaid eligible, and wanted that to cover it, they would have to provide a police report." In some cases, instead of requiring a police report, Medicaid allowed for providers to submit a form indicating that in their professional opinion a woman was raped but that she was unable to report it to the police.

However, lack of clarity about what it means to label a pregnancy as a result of rape made some abortion providers reluctant to fill out these forms out of concern for what their authorization would signify. An administrator with 30 years of experience working in an abortion clinic explained that the doctor's concern is not about whether women "really were raped.… What he's concerned about is [being] accused of Medicaid fraud." Such concerns about Medicaid fraud were common as many providers stated that they felt Medicaid would use any opportunity to review their records or attempt to fine providers for fraud. To combat such concerns, some providers required women to submit a police report to the provider, regardless of whether Medicaid required the report.

Abortion providers also reported that there is no clear medical definition of what constitutes "life endangerment" and many providers are confused about whose certification of life endangerment is needed to secure Medicaid coverage of an abortion. One abortion clinic administrator described concerns about ambiguous definitions of life endangerment that she has been facing for the last 10 years:

> We, or possibly another doctor, may believe an abortion is necessary to save the life of a pregnant woman. Oftentimes, when it goes to Medicaid, they don't agree with that assessment…. When you have a woman who needs to have an abortion right away, you can't sit and wait for a week for Medicaid to decide what to do.

Providers also reported that clinicians outside of abortion clinics are reluctant to sign forms verifying that a pregnancy is life endangering. Some Medicaid reimbursement forms require a signature from the woman's primary care provider or the physician providing care for the health condition making the pregnancy life-endangering. However, providers reported that some of these clinicians refuse to sign necessary Medicaid forms because they oppose abortion or because they too fear accusations of Medicaid fraud. In one case, described by a counselor with seven years of experience at a hospital, a

woman's primary care physician had told her that she could not use contraceptives because of her health condition, but that she could always get an abortion if necessary. When the woman approached her primary care physician about signing the paperwork necessary for Medicaid coverage of abortion, he refused to sign the form, because, in the abortion counselor's words, the primary care physician "does not believe in abortion. He told her she'd die, but wouldn't sign the form."

The same themes of ambiguous definitions of rape and life endangerment emerged in our interviews with women. In one example, Tasha, a 37 year-old single mother from Arizona had a heart condition and was advised by her doctor not to get pregnant because it would endanger her life. When faced with an unplanned pregnancy, she felt that her only option was termination and sought Medicaid coverage for the procedure. She explained that: "I wasn't eligible to have this [abortion] covered under that regulation [Hyde Amendment] because…it was some stupid thing about [the] percentage of my heart that's dead is not enough…. It's not life threatening enough for them to cover it."

Despite the numerous problems providers had with filing qualifying claims, most said they rarely seek help from Medicaid staff to resolve questions about current cases or past denied claims due to a lack of a direct relationship with knowledgeable Medicaid personnel and due to negative experiences working with Medicaid in the rare cases when they had reached out to them. The experience of one clinic administrator who sought help from Medicaid exemplifies the challenges to establishing a positive working relationship with Medicaid likely experienced by many health care providers both in and outside of clinics. After asking a Medicaid staff person some questions about filing abortion claims, the administrator said the Medicaid official responded: 'Some of this stuff is on our website. Why are you here? Just read the website." However, the administrator had already reviewed the website and explained that "there were things that were unclear to me…. We are just trying to understand the system so that we can utilize it for the health and well being of the client."

In addition to these challenges working with Medicaid, providers also reported difficulties offering women Medicaid-covered abortion care because of "low and slow" reimbursement. Almost all of the providers said reimbursement rates were lower than the cost of providing care and that filed claims were processed very slowly. The few providers who were successful in navigating the Medicaid process and securing reimbursement said that the high administrative costs associated with filing and following up on claims raised questions of whether it is "worth it" to work with Medicaid. One hospital physician with nine years of experience in abortion care expressed it this way:

> The procedure needs to be reimbursed in a very reasonable way. Now, there are certain states that they [abortion providers] 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 for people to do those procedures.

Consequences of Challenges Working with Medicaid: The challenges that women and providers face in their attempts to work with Medicaid affect the ways in which abortion providers deliver care. Many abortion providers we spoke with had long ago given up on contracting with Medicaid or filing abortion-related claims, meaning women seeking care at their clinics had to come up with other means to pay for abortion services. The providers who continued to work within the Medicaid system reported experiencing considerable frustration and dedicating substantial resources to filing claims, exposing themselves to potential financial loss. One physician, who had provided abortion care at clinics for 15 years, explained that despite not being adequately compensated by Medicaid, she feels compelled to provide needed care to women: "I think they [Medicaid] get away with it [not reimbursing] because we're so overwhelmed with all the paperwork and everything that we don't have time really.

Usually, you just write it off or you don't pursue it, but…we're not going to turn someone away." Providing care with little to no financial compensation from Medicaid, however, came at a cost. In a few extreme cases, providers reported cutting back on staff or cutting staff salaries to compensate for Medicaid's refusal to pay claims or to pay only a small portion of filed claims.

Because of the challenges abortion providers and women face in working with Medicaid, most Medicaid-eligible women do not have the option to use their insurance for abortion care. This means that women are forced to find other ways to pay for their abortion. In our interviews with women, many reported turning to drastic measures to pay for their procedures. Women described taking out payday loans, delaying bill payments, pawning jewelry, selling drugs, performing sex work, and borrowing money from friends and family in order to raise money for abortion. As one woman stated:

> I had to put off *a lot.* I sacrificed so much just so I could come up with this money…. Like my *light,* I had to do payments 'cause they were about to shut it off 'cause…my income was very low. And it was *embarrassing*…. I had to survive off food boxes too. I would go to the food bank and get food boxed…but like sometimes toilet paper – it was just little things like that that were missing and I had to sacrifice real quick." (Malia, age 19, Arizona)

In addition to the financial burden of having to come up with the money to pay for an abortion, women's scramble to secure payment for terminations can lead to delays in obtaining timely abortion care, preventing women from accessing treatment for life-threatening conditions, and in some cases, preventing women from obtaining abortion care altogether. One abortion clinic counselor we interviewed explained how women find themselves in this position:

> There are certainly women who have an unwanted pregnancy, and wish to terminate, and don't have the funds to. They may, out of necessity, continue the pregnancy because they don't even have $340 dollars to do the termination at that early stage. I've certainly seen people that are as much as 20 weeks [gestation], and when we get to that point, our services are jumpin' to roughly $2,000, and if they don't have $340, they may not have the $2000.... That might be financially impossible for the patient to get in a timely manner.

Delays obtaining an abortion or being denied abortion care altogether have a significant impact on women's health and the quality and direction of their lives. In response, abortion providers and abortion funds[b] have stepped forward to help support women in obtaining timely and affordable abortion services. One physician with 20 years of experience providing care at an abortion clinic described the collaboration of support from community members to ensure that women can access abortion services. She said, "You have caring people that work in this field…. We take the burden of this state not having Medicaid fund abortion and we rely on donations and our budget and our staff, and the community to help these women."

Rare But Successful Models for Navigating Medicaid: Though the preponderance of our findings point to the failings of the Medicaid system, we also found that women and providers in a minority of states have developed systems to overcome barriers to working with Medicaid, and that Medicaid, when it works, can be a reliable and important source for coverage of a range of reproductive health services, including abortion.

The majority of the successful models emerged from states where Medicaid covers abortion in most circumstances and where there is broad and established political support for public funding for abortion. However, we also found evidence of success in improving the functioning of Medicaid in a small number of states where abortion is only covered in Hyde-qualifying circumstances. In these states,

[b] An abortion fund is a non-profit organization that provides financial assistance to women seeking abortion care. For more information, visit www.fundabortionnow.org.

changes to the Medicaid system were sparked by women's health advocates and abortion providers who were frustrated and outraged by the undue burden that bureaucratic Medicaid policies and practices place on women and abortion providers.

Our findings are consistent with, and expand on, the work of other researchers and advocates who have implemented strategies to improve women's and providers' experiences working with Medicaid. By combining our own findings with the work of other researchers and advocates, we have developed a number of evidence-based actions that stakeholders can employ in their communities to reform Medicaid. Looking closely at these identified strategies, we find that there are a number of effective policy, advocacy, and practice-based strategies that can help improve women's access to timely abortion care. We summarize the strategies briefly below and in Table 1.

We found that interventions to streamline Medicaid enrollment procedures, such as working with Medicaid to revise and pare down complicated eligibility and enrollment forms and creating multiple entry points where women can enroll in Medicaid, can improve women's experiences with the insurance program. Furthermore, the development and distribution of educational materials about Medicaid enrollment and policies on abortion helped to inform women about the availability of coverage and how to obtain it.

Abortion providers also developed a number of strategies that they implemented in their individual practices that improved their experiences working with Medicaid. The use of electronic billing systems, which led to streamlined, consistent, efficient, and relatively simple claims procedures, improved abortion providers' experiences working with Medicaid and their ability to secure reimbursement in qualifying cases. Other strategies that providers found helpful and could be implemented in individual practices that provide abortion included developing and maintaining relationships with Medicaid staff, building savvy billing departments that focus their energies on billing issues, and encouraging clients to advocate for their own funding if coverage is rejected.

Table 1. Evidence-Based Action Steps that Advocates, Abortion Providers, and Policymakers Can Implement to Expand Medicaid Coverage of Abortion		
Challenge	**Potential implementer**	**Action step**
Women face difficulties enrolling in Medicaid	*Advocates* and *abortion providers*	• Develop and distribute educational materials for women about the Medicaid eligibility and application process; outline what women can expect when they enroll, and where they can go for support if they have difficulties enrolling.[11] • Implement local solutions to eliminate financial barriers women experience when applying for Medicaid.[12]
	Advocates, *abortion providers*, and *policymakers*	• Advocate for women to be able to enroll in Medicaid in multiple places, such as online, at family planning or mobile clinics, and at locations with extended operating hours.[12-13] • Work with Medicaid to revise and pare down complicated eligibility and enrollment forms to make them easier to fill out.[8-9, 14-16] • Call for fewer required proof-of-eligibility documents for enrolling pregnant women in Medicaid, and campaign for presumptive eligibility and rapid enrollment of pregnant women in Medicaid.[12]
Even when insured, women face barriers securing Medicaid coverage of abortion.	*Advocates* and *abortion providers*	• Develop and distribute resources designed to educate women and other stakeholders about federal and state Medicaid policies on abortion, the information women are required to tell Medicaid when seeking abortion coverage, which MCOs cover abortion, the procedures for obtaining coverage from Medicaid, and the names of facilities that accept specific MCOs.[12-14, 16-21] • Support women in acting as their own advocates, and encourage them to contact Medicaid to determine their benefits, or to find out why coverage for an abortion has been denied.[9]
	Advocates, *abortion providers*, and *policymakers*	• Utilize letters, educational materials, meetings, and/or trainings to educate Medicaid and Medicaid MCOs about the circumstances under which women's abortion should be covered according to state and federal policies.[14, 18] • Advocate for Medicaid to make information about abortion coverage easily accessible on their website.[13] • Work with Medicaid to simplify complicated forms women fill out verifying the circumstances of an abortion, and suggest the removal of requirements to prove an abortion qualifies for coverage, such as the submission of a police report in the case of rape, or medical records in the case of life endangerment.[8-9, 14]
Abortion providers face challenges working with Medicaid to offer abortion care.	*Abortion providers*	• Consider using electronic billing systems for filing Medicaid claims, when available, rather than paper-based systems.[12, 22] • Build relationships with a Medicaid staff person who is knowledgeable about billing procedures for abortion care.[8-9] • Invest in building savvy billing departments that can readily maneuver the billing process, develop and implement billing strategies, and be assertive when negotiating with Medicaid.[8-9]
	Advocates and *abortion providers*	• Talk with physicians within and outside of abortion clinics about what it means to sign Medicaid forms indicating a physician certifies that a woman is seeking an abortion due to rape, incest, or life endangerment.[8, 14]
	Advocates, *abortion providers*, and *policymakers*	• Work with Medicaid officials to simplify forms and administrative processes required to submit a Medicaid claims.[15] • Urge Medicaid to improve reimbursement rates for abortion care.[8-9] • Demand that Medicaid provide clear rejection forms that explain claim denials.[9] • Advocate for a policy whereby Medicaid has to pay late fees if it does not reimburse abortion providers in a timely manner.[12]
	Policymakers	• Support legal and advocacy actions targeted at ensuring Medicaid pays qualifying claims at appropriate reimbursement levels and provides sustained increases to meet those rates.[8-9, 23]

Successful advocacy and policy level actions included both collective legal action and multi-pronged collaborative efforts. Some abortion providers said they reached out to national legal advocacy organizations when they first experienced problems working with Medicaid. Lawsuits brought by legal advocacy organizations on behalf of abortion providers for non-payment were described as powerful and inspiring actions, often resulting in quick payment on current claims. However, broad-based, state-level interventions appeared to hold the most promise for increasing women's access to Medicaid coverage. The collaborative efforts of advocates, abortion providers, and legal experts in some states led to significant improvements on the ground, as well as at the policy level. In one state, a group came together to implement an effective statewide program of activities that included simplifying Medicaid claims forms and creating educational materials that explain when Medicaid should cover abortion care. These activities built on a previous legal victory to remove burdensome requirements that women submit paperwork "proving" the circumstances of her abortion (such as a police report in cases of rape). These strategies are discussed in detail in four *Take Action* guides that we created to provide women, abortion providers, advocates, and policymakers with a menu of actions they can take to help expand women's access to Medicaid-covered abortion and reduce providers' service delivery challenges.[c]

Impact of a Well-functioning Medicaid System: In the few states where Medicaid coverage of abortion functioned well, either due to existing political support for public funding for abortion, or the efforts of stakeholders who made an unfriendly Medicaid system work better, women and abortion providers reported satisfaction with the Medicaid system. Women in these states appeared to experience relatively few barriers to accessing Medicaid or abortion care. In fact, they reported it was easy to navigate Medicaid enrollment procedures, and that Medicaid adeptly expedited their applications when they disclosed they were pregnant. For example, Amy, 37, from Oregon, explained, "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." In addition, most women eligible for Medicaid in these states were readily able to access abortion care benefits and found Medicaid staff responsive to questions women had about Medicaid enrollment or benefits. My further described her enrollment experience: "When you go in to sign up, they ask you if you're continuing or terminating and I just asked them, 'What if I was terminating?' and they just told me it covered that too."

Abortion providers in these states reported facing very few Medicaid-related service delivery challenges. They described an easy-to-navigate billing process and reported experiencing remarkably few rejections of qualifying claims. Though there were some notable exceptions, providers in these states also noted that reimbursement for abortion care was adequate and timely. Of the reimbursement for abortion services, an abortion clinic administrator with 20 years of experience said that: "We do think about the reimbursement rates and want to make sure that we are not donating those services…but mostly we are happy with it…. The process works very well for us." In addition, women and abortion providers reported that Medicaid staff in these states were responsive, helpful, and able to answer questions about Medicaid enrollment, abortion coverage, and reimbursement for abortion care. We also found this to be true in our mystery caller evaluation of Medicaid where Medicaid staff in these states

[c] For more information about these *Take Action* guides, please see our website (http://www.ibisreproductivehealth.org/work/abortion/barriers.cfm).

were able to more adeptly and correctly answer our questions about when Medicaid covers abortion care and how to obtain coverage.

Discussion: Medicaid can be a critical source of health insurance for millions of American women. However, an ill-functioning Medicaid system and federal and state restrictions on abortion coverage contribute to unequal access to abortion for low-income women. Our research shows that many women face difficulties enrolling in Medicaid, contacting Medicaid, learning about abortion care benefits, and "proving" the circumstances of their abortion to Medicaid – all barriers that can needlessly delay women from obtaining timely abortion care. We also found that restrictions on the circumstances under which Medicaid covers abortion can effectively lead to prohibitions on coverage in all cases.

Unable to use their Medicaid to cover abortion care, women struggle to raise the money needed to cover the procedure, often finding themselves stuck in a cycle of gathering money only to find that the cost of an abortion has increased because the pregnancy has progressed. Given that the earlier abortions are obtained, the less expensive, less complicated, and more widely available they are,[24] findings about the delays women experience enrolling in Medicaid and obtaining abortion care are troubling. More troubling are our findings that requirements to prove to Medicaid that an abortion is life threatening "enough" can not only delay women from obtaining care, but may also threaten women's health and increase their risk of poor health outcomes.

Our findings about the devastating impact that the Hyde Amendment can have on women are consistent with previous research. Indeed, it has been documented that low income women can be delayed up to three weeks in obtaining an abortion while they seek the money required for the procedure.[25-26] Moreover, a 2009 literature review examining the impact of Medicaid funding restrictions on abortion found that an estimated 25 percent of Medicaid-eligible women who would have had an abortion if funding had been available instead carry their pregnancies to term.[27]

Of course, bans on abortion coverage do not only affect low income women. As of 2011, there are a number of policies in place that restrict public funding for abortion for other groups of women. The Indian Health Service (IHS), responsible for providing health services to Native American people, limits abortion coverage to cases of rape, incest, and life endangerment.[28] Native American women remain subject to these conditions, even when residing in one of the 17 states that offer abortion coverage in most cases. Similar restrictions limit access to abortion coverage for women in the US military: federal law prohibits the use of Department of Defense funds for abortion except in cases of life endangerment.[29] Like low income women who are largely prevented from access to abortion coverage under the Hyde Amendment, Native American women and women in the military often face difficulties accessing abortion care, as well as abortion coverage in allowable cases.[28, 30]

Our research also revealed that restrictions on Medicaid coverage of abortion create service delivery challenges for abortion providers, thus increasing providers' reluctance to work with the public insurance program. Abortion providers who continue to work with Medicaid face numerous difficulties filing claims in cases of rape, incest, and life endangerment, revealing how current Medicaid policies and procedures offer little guidance on the circumstances which qualify for Medicaid coverage and do not empower abortion providers to use their professional judgment about what is in the best interest of the woman, leading to rejected claims, protracted "claims wars," and billing disagreements.

Abortion providers are not unique in facing these challenges working with Medicaid; nationwide, physicians report reluctance to work with Medicaid largely because of long delays in reimbursement.[31-32] Our findings are consistent with this national trend, although we posit that abortion providers face heavier bureaucratic requirements, stronger political opposition, and greater stigma when working with Medicaid than other health service providers.

Given the number of difficulties that abortion providers do face in working with Medicaid, we were surprised to find that some providers have identified a range of strategies to improve women's access to Medicaid coverage generally and to Medicaid coverage of abortion specifically. These providers utilized a number of means, including policy mechanisms and grassroots advocacy strategies, as well as strategies to improve the internal workings of their individual clinics. Though we found that successful models of working with Medicaid were rare and often hard won, these models also demonstrate that the public funding system can be made to meet women's abortion care needs in a way that does not overburden abortion providers.

Conclusion: Abortion is a safe and common component of women's health care. In order to protect women's health and ensure they can exercise their reproductive rights, all women should have equal access to abortion care, regardless of their income level. The documented challenges and successes experienced by women and abortion providers in working with Medicaid provide evidence about the need for change, as well as insight into some tools necessary for enacting much needed reforms to the Medicaid system. Strategies employed by abortion providers and advocates show that while we work to repeal federal and state level restrictions on abortion coverage in the long term, we can simultaneously take action to remove some of the obstacles that women and providers currently face in working with Medicaid. It is our hope that our documentation of the devastating impact of the Hyde Amendment, as well as strategies for navigating the Medicaid system, will contribute to the chorus of efforts to ensure timely and equitable access to abortion care for all women.

References

1. Fried MG. The Hyde Amendment: 30 years of violating women's rights. Los Angeles, CA: Center for American Progress. 6 October 2006. Available from: http://www.americanprogress.org/issues/2006/10/hyde_history.html.
2. Guttmacher Institute. State Policies in Brief. State funding of abortion under Medicaid. New York: Guttmacher Institute. November 2011. Available from: http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf.
3. Henry J. Kaiser Family Foundation. Fact Sheet #7235-04. The Medicaid program at a glance. Washington, DC: Henry J. Kaiser Family Foundation. January 2010. Available from: http://www.kff.org/medicaid/upload/7235-04.pdf.
4. Schneider A, Elias R, Garfield R, Rousseau D, Wachino V. The Medicaid resource book. Washington, DC: Henry J. Kaiser Family Foundation. July 2002. Available from: http://www.kff.org/medicaid/2236-index.cfm.
5. Henry J. Kaiser Family Foundation. Issue Brief #7213-03. Medicaid's role for women. Washington, DC: Henry J. Kaiser Family Foundation. October 2007. Available from: http://www.kff.org/womenshealth/upload/7213_03.pdf.
6. Department of Health and Human Services (DHHS). Women's health issues: An overview. Office on Women's Health. Washington, DC: DHHS. 2001.
7. Henry J. Kaiser Family Foundation. Policy Brief #7194. Low-income adults under age 65 – many are poor, sick, and uninsured. Washington, DC: Henry J. Kaiser Family Foundation. June 2009. Available from: http://www.kff.org/healthreform/upload/7914.pdf.
8. Kacanek D, Dennis A, Miller K, Blanchard K. Medicaid funding for abortion: Providers' experiences with cases involving rape, incest and life endangerment. *Perspectives on Sexual and Reproductive Health*. June 2010; 42(2):79-86.
9. Dennis A, Blanchard K, Córdova D. Strategies for securing funding for abortion under the Hyde Amendment: A multi-state study of abortion providers' experiences managing Medicaid. *American Journal of Public Health*. November 2011; 101(11):2124-2129.
10. Dennis A, Blanchard K. A mystery caller evaluation of Medicaid staff responses about state coverage of abortion care. *Women's Health Issues*. (Online ahead of print). December 2011; doi: 10.1016/j.whi.2011.11.001.
11. ACCESS/Women's Health Rights Coalition. Barriers to entry: Ensuring equitable and timely access to Medi-Cal for pregnant women. Oakland, CA: ACCESS/Women's Health Rights Coalition. March 2009.
12. Ibis Reproductive Health. Documenting the impact of the Hyde Amendment on women's abortion access. Cambridge, MA: Ibis Reproductive Health. 2011. Available from: http://www.ibisreproductivehealth.org/work/abortion/barriers.cfm.
13. Morrow B, Horner D. Harnessing technology to improve Medicaid and SCHIP enrollment and retention practices. Washington, DC: The Children's Partnership and the Kaiser Commission on Medicaid and the Uninsured. May 2007. Available from: http://www.childrenspartnership.org/AM/Template.cfm?Section=Reports1&Template=/CM/ContentDisplay.cfm&ContentID=10995.
14. Sills S, Frietsche S. Removing barriers to Medicaid-funded abortion: What advocates can learn from the Pennsylvania experience. New York: Institute for Reproductive Health Access and Women's Law Project. 2004. Available from: http://www.nirhealth.org/sections/ourprograms/documents/removingbarriers2.pdf.

15. Ku L, MacTaggart P, Pervez F, Rosenbaum S. Improving Medicaid's continuity of coverage and quality of care. Washington, DC: Association for Community Affiliated Plans. July 2009. Available from: http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_66898AB4-5056-9D20-3D5FC0235271FE99.pdf.
16. Sills S, Jaffe R, Rivera L. Protecting reproductive health care for low-income women. New York: The Institute for Reproductive Health Access. 2002. Available from: http://www.prochoiceny.org/assets/files/2002reproguide.pdf.
17. Goldstein E, Teichman L, Crawley B, Gaumer G, Joseph C, Reardon L. Lessons learned from the National Medicare and You Education Program. *Health Care Finance Review*. Fall 2001; 23(1):5-20.
18. Horsley S. Takin' it to the states: A toolkit for expanding abortion and reproductive justice in your state. Boston: The National Network of Abortion Funds. 2008. Available from: http://www.fundabortionnow.org/sites/default/files/national_network_of_abortion_funds_state_advocacy_toolkit.pdf.
19. Sills S. Roundtable on public funding for abortion: Current status and future strategies. Philadelphia: Institute for Reproductive Health Access. 12 December 2002.
20. NARAL Pro-Choice NY Foundation. Book of choices: New York state resources for unplanned pregnancy. New York: NARAL Pro-Choice NY Foundation. 2011. Available from: http://www.prochoiceny.org/boc/.
21. Martelle M. Resource guide for New York state abortion providers: Helping low-income women pay for abortions in New York state. New York: Low Income Access Program at the National Institute for Reproductive Health and NARAL Pro-Choice New York. 2008. Available from: http://www.prochoiceny.org/assets/files/providerresourceguide.pdf.
22. Blanchfield B, Heffernan J, Osgood B, Sheehan R, Meyer G. Saving billions of dollars—and physicians' time—by streamlining billing practices. *Health Affairs*. June 2010; 29(6):1248-1254.
23. Al Agili DE, Pass MA, Bronstein JM, Lockwood SA. Medicaid participation by private dentists in Alabama. *Pediatric Dentistry.* July-August 2007; 29(4):293-302.
24. Jones RK, Zolna MRS, Henshaw SK, Finer LB. Abortion in the United States: Incidence and access to services, 2005. *Perspectives on Sexual and Reproductive Health*. March 2008; 40(1):6-16.
25. Trussell J, Menken J, Lindheim B, Vaughan B. The impact of restricting Medicaid financing for abortion. *Family Planning Perspectives*. May/June 1980; 12(3):120–123 & 127–130.
26. Henshaw SK, Wallisch LS. The Medicaid cutoff and abortion services for the poor. *Family Planning Perspectives*. 1984; 16(4):171–172 & 177–180.
27. Henshaw SK, Joyce TJ, Dennis A, Finer LB, Blanchard K. Restrictions on Medicaid funding for abortions: A literature review. New York: Guttmacher Institute. June 2009. Available from: http://www.guttmacher.org/pubs/MedicaidLitReview.pdf.
28. Schindler K, Jackson AE, Asetoyer C. Indigenous women's reproductive rights: The Indian Health Service and its inconsistent application of the Hyde Amendment. Lake Andes, SD: Native American Community Board. October 2002. Available from:

http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/indigenous_women.pdf.
29. Boonstra H. Off base: The U.S. military's ban on privately funded abortions. *Guttmacher Policy Review*. Summer 2010; 13(3):2-7. Available from: http://www.guttmacher.org/pubs/gpr/13/3/gpr130302.html.
30. Grindlay K, Yanow S, Jelinska K, Gomperts R, Grossman D. Abortion restrictions in the U.S. military: Voices from women deployed overseas. *Women's Health Issues*. July-August 2011; 21(4):259-264.
31. Cunningham PJ, Hadley J. Effects of changes in incomes and practice circumstances on physicians' decisions to treat charity and Medicaid patients. *The Milbank Quarterly.* 2008; 86(1):91–123.
32. Cunningham PJ, O'Malley AS. Do reimbursement delays discourage Medicaid participation by physicians? *Health Affairs.* January/February 2009; 28(1):17-28.