TAKING INSURANCE IN ABORTION CARE: POLICY, PRACTICES, AND THE ROLE OF POVERTY

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ABSTRACT

Most women seeking abortion pay out-of-pocket for care, partly due to legal restrictions on insurance coverage. These costs can constitute a hardship for many women. Advocates have sought to ensure insurance coverage for abortion, but we do not know whether the intermediaries between policy and patient — abortion-providing facilities — are able and willing to accept insurance.

We interviewed 22 abortion facility administrators, representing 64 clinical sites in 21 states that varied in their legal allowance of public and private insurance coverage for abortion, about their facility’s insurance practices, and experiences.

Respondents described challenges in accepting public and/or private insurance that included, but were not limited to, legal regulations. When public insurance broadly covered abortion, its low reimbursement failed to cover the costs of care. Because of the predominance of low income patients in abortion care, this caused financial challenges for facilities, leading one in a state that allows broad coverage to nonetheless decline public insurance. Accepting private insurance carried its own risks, including nonpayment because costs fell within patients’ deductibles. Respondents described work-arounds to protect their facility from nonpayment and enable patients to use their private insurance.
The structure of insurance and the population of abortion patients mean that changes at the political level may not translate into changes in individual women’s experience of paying for abortion.

This research illustrates how legal regulations, insurer practices, and the socioeconomics of the patient population matter for abortion-providing facilities’ decision-making about accepting insurance.

Keywords: Abortion; insurance; Medicaid; poverty

INTRODUCTION

On July 8, 2015, U.S. Congressional Representative Barbara Lee introduced the Equal Access to Abortion Coverage in Health Insurance Act, known as the EACH Woman Act. The act would require public and private insurance providers to cover abortion care. Although unlikely to come up for a vote, let alone be passed, while the antiabortion Republican party holds the majority of seats in Congress, the act represents the latest foray in decades of political contestation over insurance coverage for abortion. In 1976, with the Hyde Amendment, Congress voted to exclude abortion care from the services federal funds contributed to public health insurance (known as Medicaid) can cover, save for abortion for reasons of rape or incest, or when the pregnant woman’s life is in danger. The Hyde amendment has been regularly reapproved over the years, and 33 states and the District of Columbia have mirrored that language to similarly restrict the use of state funds contributed to public insurance for abortion (Guttmacher Institute, 2017b). Even with Hyde still firmly in place, in 2009, controversy over insurance coverage for abortion led to delays in the approval and implementation of the Affordable Care Act (Gold, 2010). To placate anti-abortion members of congress, the act includes special rules regarding abortion services, including requiring separate, opt-in funds for abortion coverage for plans offered through the newly established health exchanges (Cohen, 2010; Schaler-Haynes, Chesnokova, Cox, & Feinstein, 2011) and allowing states to ban private insurance plans from covering abortion (Rosenbaum, 2011).

As these policy fights have played out, abortion remains one of the most common medical procedures in the United States, with one in three women obtaining abortion care in her lifetime (Jones & Kavanaugh, 2011). Currently, most women obtaining abortions pay out-of-pocket, even those eligible for insurance coverage (Jones, Upadhyay, & Weitz, 2013). Among insured women, regardless of type of insurance, only about one-third receive coverage for their abortions (Bessett, Gorski, Jinadasa, Ostrow, & Peterson, 2011; Roberts, Gould, Kimport, Weitz, & Foster, 2014). Many women with private insurance plans fail to use their coverage for reasons including because they assume
abortion is not a covered service (Cockrill & Weitz, 2010; Van Bebber, Phillips, Weitz, Gould, & Stewart, 2006) and because they were given incorrect information regarding their plan’s policies on covering abortions (Jones et al., 2013). Staff confusion and/or obfuscation regarding insurance coverage for abortion are not restricted to private insurers. Dennis, Blanchard, and Córdova (2011) found that Medicaid representatives in states that permit the use of state funds to cover abortion care were sometimes reluctant to give information about abortion services and often discouraged callers from seeking coverage at all.

The costs women bear to obtain abortion care are not insignificant (Van Bebber et al., 2006). In 2009, the median cost of a first trimester abortion, which constitute nearly 90% of all procedures (Pazol et al., 2011), was $470 and cost ranged as high as $629 (Jones & Kooistra, 2011). Women additionally face costs related to travel, lost work time, and childcare for existing children. Roberts et al. (2014) found, for example, that half of the women in their sample spent more than one-third of their monthly income to cover the costs associated with their abortion, potentially foregoing rent, utilities, and even food. Cost sometimes becomes a complete barrier to abortion; Cook, Parnell, Moore, and Pagnini (1999) estimate that lack of public funding for abortion contributes to as many as one-third of women who would choose abortion instead carrying their pregnancies to term due to their inability to afford abortion services. Scholars have used these findings to argue for the importance of public insurance coverage for abortion (Dennis, Manski, & Blanchard, 2015).

However, while the literature has examined the structure of insurance policies around abortion care and how women actually pay for care, little work has honed in on a third aspect of the insurance and payment for abortion services equation: the role of the facility. As an intermediary between patients and insurers, providers play a key role in securing insurance coverage for abortion care, but we know little about how they navigate this task. Research has shown that the actions of individual providers and facilities matter for securing Medicaid coverage for individual, eligible abortions (Dennis & Blanchard, 2013; Dennis et al., 2011), but also that more than half of Medicaid-eligible cases are not reimbursed (Kacanek, Dennis, Miller, & Blanchard, 2010). If providers do not accept insurance, or experience the obstacles to accepting insurance as prohibitive, changes in public policy such as the EACH Woman Act will not impact women’s experience of paying for care.

The stakes are high. Abortion care is gendered care: women (and a very small number of transmen) get abortions. Policies and practices related to care are thus inherently gendered and can further — or potentially contest — gender inequality. Additionally, 42% of abortion patients report household incomes below the federal poverty line (Jones & Kavanaugh, 2011) meaning that insurance practices have a notable impact on economically vulnerable populations, with abortion decisions impacting not only the woman herself but also other people in her life (Dennis, Manski, & Blanchard, 2014). Abortion patients are also disproportionately women of color (Jones & Kavanaugh, 2011), meaning
that obstacles to care created by insurance coverage policies and practices have disproportionate impact on populations that are already socially marginalized (Dehlendorf, Harris, & Weitz, 2013).

Here, we investigate facilities’ practices around accepting public and private insurance for abortion care under a variety of regulatory settings, including broad allowance and broad prohibition of abortion coverage. We find that legal allowance and prohibition mattered to facilities’ deciding to accept insurance, as did public insurance’s reimbursement rates and the structure of private insurers. We further identify how the predominance of low income women in the patient population produces difficulties unique to abortion care that can make the costs of accepting insurance outweigh any benefits. Our findings illustrate how legal regulations and insurer practices as well as the socioeconomics of the patient population matter for abortion-providing facilities’ decision-making about accepting insurance.

**METHODS**

To examine the insurance policies and practices of facilities that provide abortions, we conducted key informant interviews with staff members at abortion-providing facilities who had familiarity with billing practices and policies. Because target respondents would have extensive experience in the administrative aspects of abortion provision, with some having insight into insurance practices and decisions for more than one clinical site and/or across multiple regulatory settings, we considered them key informants. As part of a separate study, we worked with the National Abortion Federation (NAF), a professional association of abortion providers in the United States that includes both individual people and facilities, to identify member facilities that would be interested in participating in research about abortion and insurance. Because not all abortion providing facilities are NAF members, we also drew on professional contacts to identify administrators at non-NAF facilities who might be willing to participate in this study.

Anticipating that state policies might impact facility insurance practices, we sorted facilities based on the state laws regarding public and private insurance coverage for abortion of the state(s) they were located in. Facilities fell into three categories: they were located in states with (1) public and private insurance coverage broadly allowed; (2) private insurance coverage broadly allowed but public insurance coverage broadly restricted (i.e., limited to the exceptions to the Hyde amendment: rape, incest, or life endangerment); or (3) private insurance coverage restricted (e.g., prohibiting abortion coverage in plans available through the state health exchange) and public insurance coverage broadly restricted. There are no states that fit the fourth scenario of this cross tab of broad public insurance and restricted private insurance coverage.
Next, the second author emailed the administrative contact at up to five facilities in each category, purposively chosen for geographic diversity. The email described the study as an investigation into facility policies and practices related to accepting insurance coverage for abortion and requested a phone interview with whomever at the facility would be most knowledgeable on this topic (with additional inclusion criteria that prospective participants be over 18 and English-speaking). We sent two follow-up emails, at 1 week and 2 weeks after the initial email. If we did not hear from someone at that facility, we emailed the administrative contact at another facility located in a state with the same public and private insurance allowance profile.

Between October 2015 and February 2016, we conducted 22 in-depth phone interviews. At the end of each interview, respondents were asked to invite others they thought could speak to our research questions to contact us about the study. This recruitment strategy yielded 15 interviews from direct email and seven interviews through snowball referral. Interviews were conducted by phone at a time convenient to the respondent. Most took place during business hours, while the respondent was at work. Respondents verbally consented to participate in the study and were offered a $35 gift card to compensate them for their time. We collected but did not retain contact information to mail the gift cards.

Interviews were semistructured, allowing respondents to introduce new ideas. They included questions about the respondent’s facility’s current policies and practices regarding accepting public and private insurance, the history of these practices, and the various pros and cons of current and past practices. Additionally, we collected basic demographic information about respondents and their facilities. Interviews were audio recorded and transcribed. They ranged in length from about 20 minutes (owing to the demands of the respondent’s work schedule) to an hour, averaging just under 40 minutes. All study protocols were approved by the institutional review board at the authors’ institution.

Sample Characteristics

Of the 22 key informants, all but one were women, most were white, and most held a 4-year college or advanced degree (Table 1). They ranged in age from 32 to 68. Four respondents had worked at their facility for fewer than 5 years, while the remaining 17 reported 5 years or more at the same facility, including one respondent with 27 years at her facility.

Respondents represented 16 different facilities. Eight of the facilities operated a single clinical site that exclusively or predominantly provided abortion care. Five facilities operated multiple clinical sites, ranging from two to 36, that similarly specialized in abortion care. Outpatient clinics like these account for just under half of all the abortion-providing facilities in the United States, and
provide 94% of all abortions performed annually (Jones & Jerman, 2014). The four remaining facilities represented in our sample were hospitals that offered a broad range of care. Hospitals account for 35% of the abortion providers in the United States, but just 4% of abortions performed annually (Jones & Jerman, 2014). These 16 facilities represented a total of 64 clinical sites located in 21 US states, including in all four general regions of the country: seven in the Midwest, eight in the northeast, nine in the south, and 40 in the west (most of these sites in the west were part of a single multisite facility). It is important to note that this regional distribution is not representative of the geographical distribution of providers (Jones & Jerman, 2014). This sample over-represents clinics in the west and under-represents providers in the northeast and south.

Analysis

Both authors read all transcripts in full. Because our focal unit of analysis is individual clinical sites rather than the respondent, the second author wrote a summary of the insurance policies, including reported challenges to and debates
about, for each of the facilities represented in our sample. Then, both authors examined the summaries for patterns and trends in insurance acceptance policy. We identified three broad areas relevant to insurance acceptance policies: prework to accept insurance, variation in law and coverage, and the stakes of accepting insurance. Using these general topics as sensitizing concepts (Charmaz, 2006), the first author developed an initial codebook of broad topics and concepts, which the second author used to code three transcripts, simultaneously identifying new codes and possibly redundant codes. The first author independently coded the same transcripts and compared results. Although coding was generally consistent, there were areas of disagreement, which the authors discussed and resolved. With the revised codebook, the second author coded the remainder of the transcripts.

Next, we exported the excerpts for each topic and concept code and, using modified grounded theory (Charmaz, 2006), identified emergent patterns relevant to these more general codes. Each author performed the subcoding for about half the initial codes, discussing findings regularly. We considered coding complete when no new subcodes emerged.

RESULTS

In our interviews, respondents reported that accepting insurance, both public and private, took a great deal of staff time and effort, including research, physician credentialing, and the actual work of billing insurers. Taking insurance, in other words, was work — sometimes a lot of work. That accepting insurance requires staff work, both one-time activities and ongoing tasks, is not unique to abortion care. Nonetheless, respondents identified several ways in which accepting insurance for abortion care was uniquely complicated and costly. For some facilities, accepting insurance was so complicated and costly in terms of staff time and resources that they chose not to accept insurance at all.

Identifying Insurers

In order for facilities to take insurance, they had to first identify available insurers. The patchwork of state laws restricting Medicaid and private insurance coverage of abortion made this complicated for many facilities. We start with respondents’ accounts of identifying Medicaid insurers.

In 33 states and the District of Columbia, state law broadly prohibits Medicaid coverage of abortion, with a few exceptions (e.g., pregnancy as the result of rape). On one level, it would seem that these bans would simplify facilities’ experience of deciding whether to accept public insurance: they simply could not and would not. This was the case for several respondents, who
explained their facility’s policy of not accepting Medicaid as rooted in a state law prohibition. In our sample, 21 clinical sites declined to accept public insurance because of legal restrictions on the use of Medicaid for abortion care (Table 2). The Director of Operations at a single site facility in the northeast was blunt in explaining why they do not accept Medicaid: “state Medicaid doesn’t cover abortion services. So, you know, we don’t obviously bill them, because they don’t cover.” Like many of the other sites in our sample that declined to accept Medicaid, her clinic developed their policy in response to the legal ban on public insurance coverage.

In theory, though, these laws included exceptions that allowed patients to use Medicaid for abortion care – usually for cases of rape, incest, and the life of the pregnant woman. In practice, however, facilities reported difficulty securing Medicaid coverage for these few exceptions allowed by the law. A physician at a single site facility in the west explained:

> Even in cases of rape, incest, or health of the mother, it [Medicaid coverage] is extremely rare. I just did kind of a research project […] to try to find out if they ever pay. We found 25 cases in 5 years where they paid, and they were hospital cases and the [abortion] pill. There were no abortion providers [like my facility] that provided those abortions, in other words.

As the physician explained, Medicaid did not cover abortions provided in facilities like hers, further cementing her facility’s decision not to accept Medicaid.

The Billing Coordinator at a multisite facility with clinics throughout the United States faced a different challenge in regards to securing Medicaid reimbursement for exceptional cases that the law allows coverage for. She explained that, although one of the states where they had a clinical site explicitly allowed for Medicaid insurance coverage of abortions deemed “medically necessary,” it had a parallel law that prohibited any physician who performs abortions from being credentialed by Medicaid. This created a legal paradox: without a credentialed physician, the site could not submit claims to Medicaid, even for abortions Medicaid is supposed to cover.

Not all states, however, made it difficult — or legally impossible — to bill Medicaid for abortion care, even when they had a law on the books limiting Medicaid coverage to certain circumstances. In some states, despite an ostensible ban on Medicaid coverage of most abortions, Medicaid staff interpreted allowable exceptions broadly. For example, a clinic director from a multisite

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**Table 2. Site Practices on Public Insurance.**

<table>
<thead>
<tr>
<th>State Law Regarding Public Insurance Coverage for Abortion</th>
<th>Site Accepts Public Insurance</th>
<th>Site Does Not Accept Public Insurance</th>
</tr>
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<tbody>
<tr>
<td>Prohibits broadly ($n = 22$)</td>
<td>1$^a$</td>
<td>21</td>
</tr>
<tr>
<td>Allows broadly ($n = 42$)</td>
<td>40</td>
<td>2</td>
</tr>
</tbody>
</table>

$^a$This site accepted public insurance from patients who were residents of a neighboring state that allows public insurance coverage of abortion.
facility in the south and west described how one of the states where her facility had a clinical site allowed Medicaid coverage for abortion if continuing the pregnancy could impact the woman’s mental health. She continued, “I don’t know if you have kids, but, yes, of course they have a mental impact on you.” She reported that her facility was able to regularly and successfully bill Medicaid for abortion care under that portion of the law. Thus, what could appear to be a ban on Medicaid coverage of abortion, save for specific circumstances, did not, in practice, greatly restrict the application of Medicaid funds for abortion.

Similarly, a clinic situated in a state that banned the use of Medicaid for abortion for its residents might still get reimbursed by Medicaid for care provided to patients who reside in another state. The Director of a single site facility in the Midwest noted that her facility is located near the state border, so it sees many patients from a neighboring state that allows Medicaid coverage of abortion. The facility is contracted with all the neighboring state’s Medicaid plans and has even coordinated with their Department of Health Services to expedite claim submission and processing, enabling them to take public insurance for patients who are residents of that state.

Still, as respondents explained, coverage for abortion care in states where Medicaid is broadly permitted to cover abortions was rarely straightforward either. A Billing Coordinator, whose facility had clinical sites in three states where Medicaid broadly covers abortion care, explained that these states had both standard Medicaid and Medicaid Managed Care Organizations (MCOs). In some states, MCOs will not pay for abortion care, but, as the Billing Coordinator explained, “They pay for what they call the ‘nonabortion charges,’ which is your office visit, your ultrasound, and your lab work.” Similarly, a Director of Family Planning described how many of the patients at her north-east facility come from a state with multiple Medicaid providers, only some of which cover abortion, although state law allows Medicaid coverage of abortion: “there’s some that will cover it, some that will not. So, that also adds a layer of complexity.” A Counseling Manager explained that the state where her facility is located has several versions of Medicaid, all of which pay for abortion care, but they each reimburse for abortion care differently, which the facility has to attend to in its budgeting. As these idiosyncrasies illustrate, taking Medicaid in a state that broadly allows public insurance coverage of abortion was not necessarily easy.

On the private insurance front, respondents reported that many plans simply did not include abortion as a covered benefit. Twenty-five states currently ban private insurers on the state health exchanges from covering abortion in most instances (Guttmacher Institute, 2017a). Ten of these states, moreover, ban all private insurers from covering abortion in most instances (Guttmacher Institute, 2017a). For some facilities, this simplified their insurance policies regarding private insurers since such insurers were banned from covering abortion services. In our sample, seven clinical sites were located in states where
private insurers were broadly prohibited from covering abortion care (Table 3). An additional eight clinical sites operated in states that restricted some forms of private insurance (e.g., plans purchased on the state-run health exchange).

As with Medicaid, however, there were oddities that made the private insurance experience complicated. As the Director of a single site facility in the Midwest explained, state prohibitions on covering abortion generally apply to insurance companies based in her Midwestern state, but patients may have their insurance with companies based out-of-state. Although the state her facility is in “has a law that says abortion cannot be paid for,” they have been successful billing private insurers as an out-of-network provider:

We have many women who have policies through [an insurer] which is based out of [state]. We have billed those folks’ insurance for their abortion, and there have been payments.

This facility was not alone in identifying and acting on this quirk in how state laws applied to private insurers; one other respondent described handling similar cases.

### The Costs of Accepting Public Insurance

In our sample, 42 clinical sites operated in states that broadly allow public insurance coverage of abortion (Table 2). As respondents explained, however, while the existence of public insurance coverage of abortion care was necessary for a facility to decide to accept insurance, it was not sufficient; other factors went into their facilities’ calculus of whether or not to accept Medicaid. Indeed, two of the clinical sites in our sample (one that operated as a standalone clinic and one that was part of a multisite facility) that were not subject to a state prohibition on using public insurance funds for abortion did not accept Medicaid (Table 2). Although the other 40 sites located in states where Medicaid broadly allowed coverage for abortion did accept public insurance, respondents nonetheless described tension around this practice. The interviews highlight how fraught the decision to take Medicaid can be, even in the absence of a ban on abortion coverage.

### Table 3. Site Practices on Private Insurance.

<table>
<thead>
<tr>
<th>State Law Regarding Private Insurance Coverage for Abortion</th>
<th>Site Accepts Private Insurance</th>
<th>Site Does Not Accept Private Insurance</th>
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<tbody>
<tr>
<td>Prohibits broadly (n = 7)</td>
<td>2a</td>
<td>6</td>
</tr>
<tr>
<td>Restricts some (n = 8)</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Allows broadly (n = 49)</td>
<td>47</td>
<td>2</td>
</tr>
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*These clinics accepted private insurance when the insurers covered abortion care, usually because the insurance company was based out-of-state and not subject to the state ban.
Chief among these tensions around accepting public insurance, respondents reported, was its low reimbursement rate for abortion. Despite reports from early providers of abortion care that money was a motivator to become a provider (Goldstein, 1984), our respondents reported that contemporary abortion care is poorly reimbursed. The specific dollar amount Medicaid reimburses for abortion varies by state, but interviewees universally described it as very low. From a business perspective, taking Medicaid did not always make financial sense; it did not cover the costs to the facility of providing care. As a Counseling Manager explained about her facility in the west, the Medicaid reimbursement “doesn’t even come close to the expenditures for a service.” The Director of a single site facility in the Midwest which recently raised its prices, described how they lost money when they took Medicaid: “[Even before raising our prices,] we were probably writing off about half of the fee [for aspiration procedures]. And then, for the medication [abortion], it was probably two-thirds. The reimbursement is awful.” Reimbursement rates were also generally stagnant even as costs went up. The Senior Project Director at a multisite facility with sites in the east and south noted that:

We’re probably still getting the same amount that we got when I started 13 years ago. And, you know, our prices are ever increasing, in terms of staffing and physicians and just the cost of doing business.

Other respondents described their difficulty with Medicaid’s reimbursement specifically for abortion at later gestations. Although the abortion procedure — and its associated costs — is different for later versus earlier gestations, most Medicaids offer only a single reimbursement rate for abortion. The Clinic Director at a multisite facility with clinics in the south and west explained, “they allow [reimbursement of] a certain dollar amount for that [abortion billing] code, and so it doesn’t matter if she’s 2 weeks or 20 weeks,” even though her facility’s costs were substantially different at those gestations.

Additionally, several respondents pointed out that Medicaid was slow to reimburse facilities, and consistently slower than private insurers. Respondents reported average times to payment by Medicaid that ranged from 90 to 120 days, along with experiences of payment taking far longer, including one case where payment took 2 years and other cases where the respondent described ultimately giving up on receiving payment all together.

Accepting Medicaid for any health service, with its notoriously low reimbursements and delays in payment, is a challenge for many medical practices, but it poses an especially acute problem in abortion care because of the patient mix. In the United States, abortion patients are disproportionately low income or poor. Jones and Kavanaugh (2011) found that 68.9% of abortion patients report family incomes of less than 200% of the federal poverty level. This means that many, if not most, abortion patients qualify for Medicaid, which is available to residents at or below 100% of the federal poverty level in all states and, in states that expanded Medicaid as part of the 2010 Affordable Care Act,
to residents at or below 138% of the federal poverty level. Thus, for abortion-providing facilities, accepting public insurance meant being underpaid and experiencing substantial delays in reimbursement for the majority of their patients.

The Director of Operations at a multisite facility with clinics in the south, Midwest, and west explained how the predominance of low income patients had become a financial issue in keeping her facility open: “60% of our patients overall are insurance patients and 60% of those are Medicaid patients. That becomes, financially, quite a critical issue for us [because Medicaid’s reimbursement is so low].” She was not alone. Across the interviews, respondents described the challenge of serving a high number of Medicaid patients, given Medicaid’s low and often slow reimbursement, to their ability to cover costs and continue to provide care. As the Billing Coordinator from a multisite facility with sites throughout the United States summed up, taking Medicaid posed a dilemma wherein clinics had to choose between their need to cover costs and their desire to provide abortion services to women who seek care:

> From a business perspective, it doesn’t make sense to take Medicaid. It just doesn’t. I mean, you lose money every time you see patients. But when you look at the majority of people in some of these places, you would be turning a lot of people away.

The difficulties posed by this disproportionately poor patient population were compounded by the landscape of abortion provision. The majority of abortion care in the United States (63%) is provided by outpatient, standalone facilities that primarily or exclusively provide abortion care (Jones & Jerman, 2014). Facilities like these do not offer other services that may attract a different mix of patients with different insurers and, instead, are especially vulnerable to Medicaid’s low and delayed reimbursement.

### The Costs of Accepting Private Insurance

Respondents’ accounts of working with private insurers did not include the same pitfalls of low and delayed reimbursement that characterized Medicaid, but that did not mean accepting private insurance was without problems. Working with private insurers entailed different challenges. For most of the facilities in our sample that operated in states that allowed private insurance coverage of abortion, the benefits of accepting private insurance outweighed any costs. However, some facilities decided otherwise and chose not to accept private insurance despite no state-level restriction on private insurance coverage of abortion. Specifically, one hospital and one single site facility in states with no restrictions on private insurance coverage of abortion and one hospital and three single site facilities located in states that restricted abortion coverage in plans on the health exchange judged the costs prohibitive and declined to accept private insurance for abortion care (Table 3).
Broadly, the biggest difficulty in taking private insurance was determining whether private insurers would actually pay for the abortion care their clients received. This difficulty manifested in several ways. For one, facilities often had trouble initially determining a patient’s eligibility for insurance coverage, sometimes because of the technical language of an individual plan. The Senior Project Director at a facility with clinical sites in the south and northeast explained, for example, that policies might cover abortion, but with restrictions: “we make sure that there’s no medical necessity kind of clause on it [a patient’s private insurance plan], because they can also say, ‘Oh, a termination is covered but only medical necessity,’ and each one of them can have their own definition of what ‘medical necessity’ is.” She also described complications in determining coverage depending on who was the named insured on a given plan. She said:

Sometimes there’ll be coverage for the policyholder but not for the dependent, specific to abortion. And so, for instance, like, a dad’s policy might not cover his daughter’s abortion, or his wife’s.

As these examples illustrate, for clinics whose patients used a variety of insurers and plans, keeping track of whether, when, and for whom abortion was a covered service was complicated.

Respondents further reported that private insurer representatives did not always give accurate information about coverage to facility staff members. This was not necessarily because of hostility to abortion but, more mundanely, usually owed to the bureaucracy of private insurance. The Director of a single site facility in the Midwest gave an example:

We would call their insurance company and see if it [abortion] was a covered service, and the insurance company would say “yes, and it’s a 100 percent,” and, you know, all this stuff. Well, that’s just a quote of benefits; that’s not a guarantee. And so, we would have these women come in, and they would not pay anything but their copay. We would bill the insurance, and then the insurance would in fact not pay 100 percent.

When her facility would follow-up, the insurer would reiterate that they gave a quote, not a guarantee. As this respondent further explained, “It wasn’t that they were lying to us or misleading us. You know, and they were very clear on the phone about, you know: ‘This is not a guarantee of payment; it’s just a quote of benefits.’ ” The upshot for her facility, however, was that it did not get paid for the care it provided.

Even once facility staff had confirmed a patient was eligible for abortion coverage, that did not guarantee payment. Abortion care, with an average cost of $470 in 2009 for a first trimester procedure (Jones & Kooistra, 2011), could fall within a patient’s deductible. This meant that, although abortion was a covered benefit, the patient might still be responsible for the full amount of the procedure. As the Director of Operations at a single site facility in the northeast
explained, in cases like these when a facility charged the patient only a co-pay in anticipation of reimbursement from private insurers, they risked not being paid at all:

> We ran into tons of cases where, yes, abortion was a covered service [by a private insurer], but [the cost] went to deductible, or the [patient’s] coinsurance was huge. […] A lot of times we ended up getting burned where, you know, the insurance ended up saying that the patient portion was higher than what they had originally quoted us. And then, when we billed the client [afterwards], we had a lot of cases where women no longer have the incentive to pay us, now that they were no longer pregnant.

Several other respondents similarly explained how high deductibles meant that they could not always depend on payment for patients with private insurance.

Respondents also described running up against policies in the insurance system that were incompatible with abortion care. For instance, a physician from a single site facility in the west identified a complication in securing reimbursement for medication abortion: according to the protocol approved by the Food and Drug Administration, the drug used in medication abortions must be given to the patient by a clinician; it cannot be dispensed by a pharmacist. One private insurer, by the physician’s account, however, refused to reimburse for pills given at the facility, citing their expectation that pills should be dispensed at a pharmacy: “they didn’t understand why a patient had to get the pill here and not at a pharmacy. They wouldn’t pay for it. It was huge. I fought and fought. I think about year eight I finally just gave up.” Although the insurer considered abortion a covered benefit, it simultaneously enforced policies that made it impossible to reimburse for legally dispensed medication abortion. In this way, although abortion was covered on the books for this insurer, patients could not actually use this benefit in practice.

Faced with the uncertainty of reimbursement from private insurance, regardless of what a patient’s policy specified on paper, some facilities developed a work-around to enable patients to use their insurance while also ensuring against providing free care: require upfront payment, bill insurance, and reimburse the patient for her upfront costs if and when the insurer paid. This approach is not uncommon across the health care field for services provided by an out-of-network provider but typically is not allowed when a facility has contracted with an insurer. Nonetheless, facilities like a Director of Operations’ single site clinic in the northeast regularly did so. As she related, insurers initially pushed back:

> I actually had gotten a couple of calls from [private insurers] asking why we were requiring payment upfront for a covered service. You know, in our contracts, you’re supposed to bill the insurance and then bill the client any patient portion. And so, once I explained the situation, [that we were finding] it would all go to deductible, and then the client’s incentive to pay wasn’t as strong as it is on the front end. […] And they were like, “Oh, that makes sense.”
Insurers recognized that abortion clinics were in a unique billing position. This work-around of requiring upfront payment enabled facilities to serve privately insured patients without the risk of inadvertently providing free care.

As with accepting Medicaid, the demographics of abortion patients figured into facilities’ decision-making regarding accepting private insurance, too. The Associate Medical Director at a single site clinic in the Midwest pointed out that so few of her facility’s patients had private insurance that covered abortion that it did not make sense for them to contract with any private insurers. Similarly, a Counseling Manager explained that part of the reason why her facility in the west declined to accept insurance, despite no legal prohibitions on doing so, related to the patient population it served: only about 10% of its patients had private insurance. Still, although the Counseling Manager’s facility did not do the work-around of billing insurance and reimbursing patients, they did encourage patients with private insurance to submit their bills themselves for reimbursement. Other respondents reported similar practices of encouraging patients to submit claims directly to their insurer. A physician at a single site facility in the west reported that some patients were successful in pursuing direct reimbursement: “I’ve had a few patients get reimbursed.” In other words, patients with private insurance coverage could still get reimbursed for abortion care, even without the participation of the facility.

**DISCUSSION**

With evidence that women obtaining abortions have difficulty paying for their care out-of-pocket (Jones et al., 2013; Roberts et al., 2014), advocates have begun to push to mandate public and private insurance coverage for abortion. Our interviews suggest, however, that eliminating legal restrictions may not be enough to remove the financial burdens of paying for abortion from women themselves. While the complexity of legal allowances and prohibitions on abortion coverage by both public and private insurers impacted respondents’ facilities’ decision-making around accepting abortion, other factors also mattered. Indeed, according to our respondents, taking insurance in abortion care is not always good business. They explained that, with Medicaid, facilities could expect low and sometimes nonexistent reimbursement. Meanwhile, with private insurance, facilities risked nonreimbursement because the costs of care fell within the patient’s deductible. Thus, even with a law requiring Medicaid and private insurance coverage of abortion, facilities might not receive enough in paid claims to cover the costs of providing care. Facilities might reasonably conclude that they cannot afford to take insurance and keep their doors open.

Central to understanding this possible outcome is recognition of the composition of the population of abortion patients. Certainly, there are challenges for any facility in accepting insurance, but our interviews show that the challenges

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are particularly acute for abortion providers because of the predominance of poor and low income patients – who qualify for Medicaid – and the dearth of private insurance patients. With this patient mix, abortion care provision is not lucrative – indeed, respondents reported regularly losing money on care to Medicaid recipients. It bears noting that the abortion patient population was not always this way: women seeking abortion in the initial decades after the 1973 Roe v. Wade decision were usually white and affluent (Jones, Kost, Singh, Henshaw, & Finer, 2009), seeking to avoid derailing educational and/or occupational plans (Freedman & Weitz, 2012). Contemporary abortion patients, in contrast, are predominantly low income and disproportionately women of color (Jones & Kavanaugh, 2011) who want to avoid further financial hardship (Biggs, Gould, & Foster, 2013).

Scholars have sourced this shift in the population of abortion patients to disparities in the rates of unintended pregnancy (Dehlendorf et al., 2013), with low income women and women of color more likely to experience an unintended pregnancy than white and affluent women (Finer & Zolna, 2011). Further, scholars have argued that disparities in rates of unintended pregnancy are themselves the product of unequal access to comprehensive sex education and effective contraception that is patterned by race and class (Dehlendorf et al., 2013). The predominance of low income women in abortion care – and the attendant financial strain that poses for abortion-providing facilities – in other words, is partly a result of a broader pattern of health inequalities.

The answer to whether removing restrictions on abortion coverage would substantially change the provision of abortion care is also impacted by the existing landscape of abortion providers. It is reasonable to expect that the changes in the regulatory environment over the decades since Roe have induced changes in the characteristics of abortion providers. Although the types of providers have not substantially changed over time (i.e., outpatient clinics continue to provide most of the abortion care in the United States, Jones & Jerman, 2014), it is likely that the increasing regulation has affected the mix of motivations to provide. Providers motivated by an ideological commitment to abortion access may weather the increasing regulation of care to the detriment of their financial circumstances, but entrepreneurial providers like those Goldstein (1984) studied in the early years of legal abortion may find it is no longer a desirable business opportunity. This complexity and regulatory environment may also operate as a barrier to new providers entering the field, in parallel to institutional structures (Freedman, 2010) and interpersonal interactions (Kimport, Weitz, & Freedman, 2016) that serve to marginalize abortion provision in medicine.

Supporting this hypothesis that contemporary abortion providers are more often ideologically motivated to provide care than spurred by a profit interest, we note that even as our respondents detailed the hardships to their facility of accepting insurance, most continued to do so when legally able. Implicit in their accounts of creating work-arounds for patients to use private insurance and
stretching their budgets in order to accept Medicaid was their commitment to preserving access to abortion, even at the expense of the financial health of their facility. Our convenience sampling methodology means we cannot know how commonly facilities opt to accept insurance despite financial penalties for doing so. Future research should investigate how widespread these practices are.

Future research should also examine the overlap between the shift in the patient population seeking abortion toward more vulnerable groups and the increase in regulation of insurance (and other aspects of abortion care). Does the fact that abortion patients are disproportionately low income and of color — i.e., socially vulnerable populations — invite or enable regulation in a way that services predominantly accessed by more privileged populations would not?

Ultimately, our study identifies how legal policy, insurer practices, and the patient population matter for clinics’ calculus as to whether to accept insurance for abortion care. By focusing on the actions of clinics themselves, we address a gap in the literature on insurance for abortion care, examining the practices of the intermediary between patients and insurance companies. To best meet the health care needs of women, particularly low income women, who most commonly pay for abortion care out-of-pocket (Jones et al., 2013; Roberts et al., 2014), we need to attend not only to how abortion is legally regulated but also what it means for abortion provision that its patient population is uniquely characterized by poverty.

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**REFERENCES**


