State-Level Research Brief

Public Funding for Abortion in Iowa

Background

The Hyde Amendment, first approved by Congress in 1976, limits women's access to comprehensive reproductive health care by prohibiting federal Medicaid funding for abortion except when a woman is pregnant as a result of rape or incest, or when her pregnancy endangers her life. States have the option to cover abortion care using state funds in broader circumstances, but only 17 currently do. In April 2012, public funding for abortion is only available in Iowa in the limited exceptions outlined in the Hyde Amendment, though in previous years funding was also available for fetal impairment.[1] According to the most recent reports from the Guttmacher Institute, public funds were used to cover only 44 abortions in Iowa in 2006, a time when public funding was available in cases of rape, incest, life endangerment, and fetal impairment; this number represents the highest recorded number of publicly funded abortions in the state since 1981.[2-8]

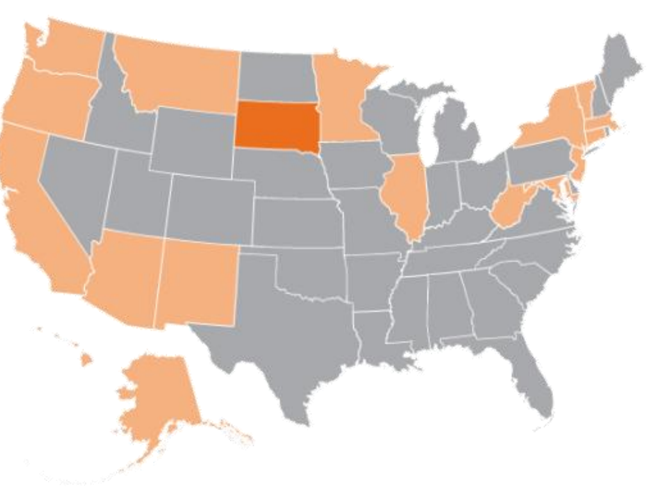
Study Description

Ibis Reproductive Health documented the experiences of abortion providers seeking Medicaid reimbursement for abortions provided in cases of rape, incest, or life endangerment of the woman, circumstances that should qualify for Medicaid coverage under the Hyde Amendment.[9-11] From 2007 to 2010, we conducted in-depth telephone interviews with abortion providers at 70 facilities in 15 states (Arizona, Florida, Idaho, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, New York, Oregon, Pennsylvania, Rhode Island, Wisconsin, and Wyoming) and asked providers about their experiences seeking Medicaid reimbursement for abortion care.

Findings

We conducted interviews with five abortion providers who reported providing 76% of the annual abortions in Iowa.[12] Interviewees worked in facilities that provided an average of 1,002 abortions annually. Four providers worked in abortion clinics and one worked in a hospital setting. Participants had an average of six years of experience in the field. Three participants were clinic administrators, one was a physician, and one held multiple roles at her facility.

Medicaid Coverage of Abortion



32 states ban state Medicaid coverage of abortion. They are legally required to provide coverage in the cases of rape, incest, and life endangerment, but usually fail to do so.

17 states provide state Medicaid coverage of abortion for low-income women in most cases.

One state provides Medicaid coverage only in cases of life endangerment.

Overall, providers described a Medicaid system that does not meet the abortion care needs of women due to several obstacles obtaining Medicaid coverage. Providers reported that Medicaid rarely covers abortion care in qualifying cases and that when it does, reimbursement is low and difficult to secure. Additionally, providers reported that it is difficult to establish that cases qualify for Medicaid coverage, particularly when a pregnancy is a result of rape or incest. As a result of these challenges, providers reported giving up on Medicaid and instead relying heavily on their own funds and abortion funds to provide financial assistance to women in need. However, providers have also developed strategies to overcome the barriers they face working with Medicaid.

Finding 1: Medicaid frequently rejects qualifying claims and reimburses at a low rate

At the time of our research, state policy indicated that Medicaid should cover abortion in cases of rape, incest, life endangerment, and fetal impairment. Providers estimated that, in the year prior to when they were interviewed, 60 women in their five clinics sought Medicaid-eligible abortions, but only 20% of those were ultimately covered by Medicaid;

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the rest were rejected. Most providers reported receiving no explanation for the reasons why claims they thought qualified for coverage were ultimately denied, making it nearly impossible to rectify any errors. As one provider explained, "We may try seven different things and then we give up because it's not worth the staff time anymore. It's just at some point…how damaged is your head from that brick wall?"

Most of the abortions reported to be covered by Medicaid took place in one hospital-based practice and were for indications of fetal impairment. Though that provider reported success at receiving coverage for many cases of fetal impairment, she expressed frustration with the limited fetal health conditions for which Medicaid would cover abortion. She explained that some claims were denied because Medicaid deemed the diagnosed fetal impairment not severe enough: "They [Medicaid] are very stingy especially when it comes to the categories of fetal anomalies…. We often disagree on indications."

In the rare circumstances that providers did receive reimbursement from Medicaid, they reported that reimbursement rates were much lower than clinic costs; in some cases, pursuing Medicaid reimbursement was not financially feasible. When asked her opinion about the reimbursement rate for abortion care, one provider responded, "[It] sucks…. Even if we would get reimbursed for abortion, who can afford to do that?"

Finding 2: It is difficult to establish that an abortion qualifies for coverage

Providers reported that they went to great lengths to establish that an abortion qualified for coverage, but that there were numerous barriers to "proving" to Medicaid the circumstances of an abortion, particularly in cases of rape and incest.

To secure Medicaid coverage of abortion in circumstances of rape, women in Iowa are required to submit proof that they reported the rape to law enforcement or to a public or private health agency within 45 days of the incident. In cases of incest, a similar report must be submitted within 150 days.[13] Providers must verify they received proof of the report and submit it along with their Medicaid claim.

Providers expressed frustration with this paperwork-heavy process and said that reporting requirements can be emotionally taxing on women and delay or prevent women from obtaining Medicaid coverage all together. Providers also said reporting requirements made it difficult for them to provide abortion care. One provider explained the barriers women and providers face documenting the circumstances of rape and incest. She said, "If we should try to get reimbursed for an abortion service as a result of the woman being a victim for rape or incest, there is a whole lot more paperwork to fill out. We need documentation from law enforcement so that already makes it go down in how many people can even qualify. So you have to be willing to file a report and all that extra angst and process for that person. We have to gather all those things, there are extra forms to fill out to document things and to turn everything in together in a package and if you don't dot one 'I' it's rejected."

Finding 3: Providers have stopped working with Medicaid

The collection of challenges providers experienced working with Medicaid led many providers to stop working with the insurance program. These providers found absorbing the costs of care preferable to working with Medicaid. One provider said of seeking Medicaid coverage of abortion, "We stopped trying. We are on the practical, on the here and now side in terms of turning in reimbursements. We are defeatists." A small number of providers, however, continued to submit claims to Medicaid out of principle. One provider explained, "We don't *expect* payment, so we go ahead and do it and bill them. That would just be the icing on the cake if they actually paid it."

Finding 4: Abortion funds and providers have stepped forward to preserve abortion access

When Medicaid coverage is inaccessible or denied, women are forced to try to raise money they do not have for the procedure. Concerned that time women spend finding the resources to pay for an abortion could unnecessarily delay

women's care, many providers said that they heavily discount their fees for low-income women and that 43% of their clients secure support from abortion funds. However, many providers said that it was financially challenging to sustain these practices. One provider said her clinic absorbed as much as $168,605 annually. Another provider explained, "We want women to have to pay as little as possible for their health care because we know financial barriers are a huge issue but we also highly value, in a monetary way, the service that we provide because it is a very high-quality service and we value our time and our skills…. So we piece things all together and those who can pay, we ask them to pay, and those who can't, we work really hard to make sure they have access."

> ***We may try seven different things and then we give up because it's not worth the staff time anymore. It's just at some point…how damaged is your head from that brick wall?***

Finding 5: Providers advocate for changes to restrictive Medicaid policies and practices

Providers reported being committed to reducing the challenges associated with securing Medicaid coverage of abortion. Strategies they employed to mitigate the difficulties they experienced included setting up meetings with Medicaid officials to try and establish relationships; copying the governor on Medicaid appeal letters in order to get a response from Medicaid; and raising awareness about the impact of low reimbursement rates on clinics and clients. A provider who organized a meeting with Medicaid officials to discuss their goals and challenges working together said, "I felt like I built some relationship so that they understood that we are not trying to rip-off the system. We are just trying to understand the system so that we can utilize it for the health and well-being of the client. It is their right, as someone who qualifies for Medicaid, to thoroughly use the system." Another provider, who was actively involved in various advocacy efforts, also highlighted the importance of being vocal. She said, "Until we make a bigger ruckus about it, there will be no attention there. So we are trying to, within the system, cause a little bit of ruckus to make some here-and-now improvements."

Summary

All of the providers we interviewed reported difficulties securing coverage for abortion care from the Iowa Medicaid program. Frequent rejections of qualifying claims, low reimbursement rates for abortion care, and barriers establishing that an abortion qualifies for coverage led many providers to stop working with Medicaid.

These findings suggest that the current public funding system for abortion care does not meet the needs of women in Iowa who qualify for Medicaid coverage. In the absence of Medicaid coverage, women must raise money for abortions or seek financial support from abortion funds or abortion providers. The process of trying to raise money can be burdensome, and lead some women to be delayed or denied in seeking care. Additionally, inefficiencies in the Medicaid abortion coverage system come at great cost to abortion providers and put financial pressure on local abortion funds; providers in Iowa reported higher numbers of women receiving financial assistance than providers in any of the other states we have studied.

It should be noted that because we interviewed only a sample of the 11 abortion providers working in Iowa,[12] the experiences of all providers may not be represented in these findings. However, our data provide a starting point for understanding the on-the-ground experiences of low-income women and abortion providers in Iowa.

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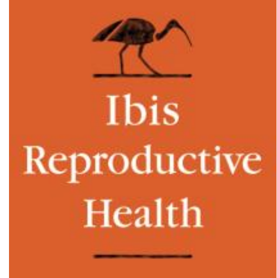
Next Steps

Evidence of the extreme challenges faced by Iowa abortion providers and their responses to those challenges can be used to improve the state funding system. Additionally, the advocacy efforts of providers in Iowa are important examples of efforts that can be taken in other states to improve women's access to Medicaid coverage of abortion.

Providers reported they plan to continue their current advocacy efforts and recommended additional actions to improve low-income women's access to abortion. First, providers recommended that Medicaid should increase reimbursement rates for abortion services to make applying for funding worthwhile. Next, they suggested Medicaid should provide more support to providers when they receive denied claims. One provider said, "They [Medicaid] could…be more helpful when a reimbursement request is rejected, offer more specific reasons as to why it was rejected and some helpful hints about how to change it so that it won't be rejected." Finally, most providers felt that the funding system could be improved by expanding Medicaid coverage to include all abortions or, at the very least, broadening the definitions of the circumstances that are covered.

Providers throughout Iowa may also consider other strategies, such as telemedicine, to reduce barriers that women face accessing abortion care. In 2008, Planned Parenthood of the Heartland in Iowa began using telemedicine to offer medication abortion at outlying clinics without a doctor on site. In Iowa, a state in which 91% of counties lack an abortion provider,[13] many women have to travel long distances to obtain abortion care; the time and costs associated with travel can be burdensome for low-income women.[14]

Creative strategies such as those described above, or found in our Take Action series,[15] may help expand access to Medicaid coverage of abortion in qualifying cases while we work toward the long-term goal of repealing the Hyde Amendment. Continued efforts to expand public funding for low-income women are needed to ensure equitable and just access to abortion services for all women in the US.



Ibis Reproductive Health aims to improve women's reproductive autonomy, choices, and health worldwide.

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