

# Removing Barriers to Medicaid-Funded Abortion

What advocates can learn from the Pennsylvania experience

INSTITUTE FOR  
REPRODUCTIVE  
HEALTH ACCESS

Women's  
Law Project



## **Institute for Reproductive Health Access**

The Institute for Reproductive Health Access examines issues of access to reproductive health services and develops innovative approaches to expand the availability of abortion and family planning services nationwide. The Institute conducts research projects, develops strategic plans, and trains communities to pro-actively address the most critical issues of family planning and abortion in the United States today. The Institute seeks to assist grassroots reproductive health organizations in confronting issues that are national in significance, yet local in approach.

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## **Women's Law Project**

The Women's Law Project is a 501(c)(3) nonprofit feminist legal advocacy organization based in Pennsylvania. Founded in 1974, the Law Project is dedicated to advancing the legal, social and economic status of women through impact litigation, public education, legislative advocacy, and one-on-one telephone counseling reaching 5,000 to 8,000 women each year.

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# Removing Barriers to Medicaid-Funded Abortion

## What advocates can learn from the Pennsylvania experience

Pennsylvania is one of thirty-four states that restrict Medicaid coverage of abortion to the most extreme circumstances – rape, incest and when a woman’s life is in danger. Advocates in Pennsylvania who assist women in obtaining abortions have found that many women face serious obstacles accessing this federally-mandated care. Recognizing a widespread problem, the Women’s Law Project, Greater Philadelphia Women’s Medical Fund, and CHOICE Hotline joined together, with the support of the Institute for Reproductive Health Access, in an effort to systematically identify and remove these barriers. *Their experiences and accomplishments reflect an important new approach to expanding abortion care for low-income women.*

- Over 17 million adult women were living below the poverty level in 2001 in the United States.
- Low-income women have significantly higher rates of unintended pregnancy, and obtain 57% of all abortions.
- Only 17 states cover medically-necessary abortions under Medicaid, yet two-thirds of all low-income women obtaining abortions live in those states.

Sources: Kaiser Family Foundation [www.statehealthfacts.kff.org](http://www.statehealthfacts.kff.org); Alan Guttmacher Institute [www.guttmacher.org/pubs/journals/3422602.html](http://www.guttmacher.org/pubs/journals/3422602.html)

Access to comprehensive reproductive health care, including abortion care, is vital for women of childbearing age. Half of all pregnancies in the United States are unintended, and half of those end in abortion. All women need access to safe, timely and affordable family planning and abortion care. Unfortunately, this is not the current reality. Onerous waiting periods, parental consent laws and a shortage of trained providers are just a few of the obstacles delaying, and sometimes preventing, women from being able to exercise their right to choose. However, one of the most intrusive barriers affects only low-income women: lack of available funding for abortion care under Medicaid.

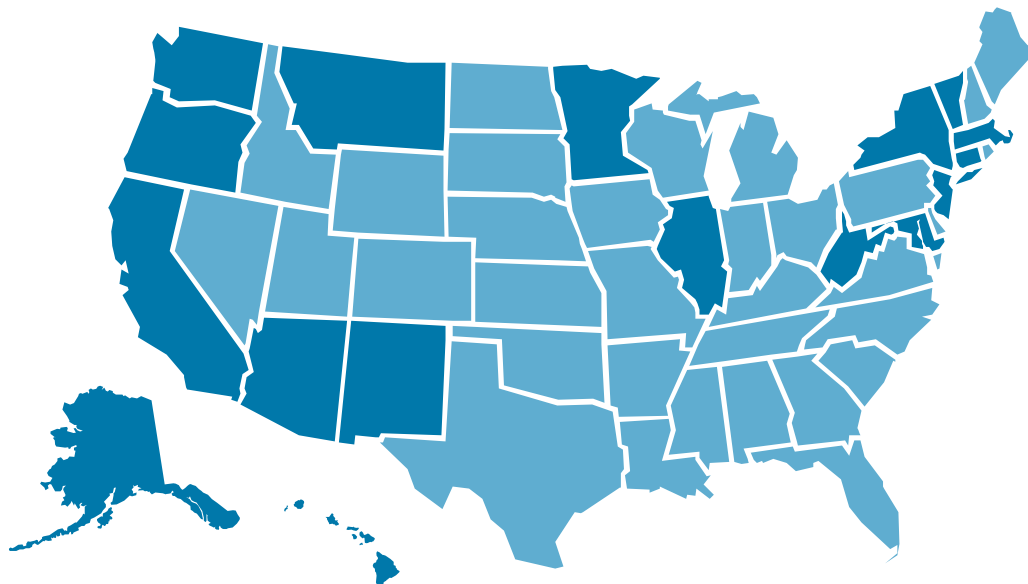
Medicaid is our nation’s public health program for the needy. Twelve million women rely on Medicaid for health care, including over 5.5 million women of childbearing age.<sup>1</sup> Medicaid pays for one out of four births in the United States and is the largest public funding source for family planning care. Recognizing the importance of helping low-income women prevent unintended pregnancy, Medicaid guarantees coverage for family planning services, including contraceptive and gynecological care. However, abortion care is treated differently.

In 1977, Congress first passed the Hyde Amendment, which restricts the use of federal Medicaid funds for abortion to cases of rape, incest or when the woman’s life is in danger. States have the option of paying for abortions in broader circumstances (“medically-necessary” abortions), but may only provide such funding solely with state dollars. Only seventeen states opt to pay for medically-necessary abortion care, either voluntarily or in response to a state court order.

*Lack of access to Medicaid-funded abortions endangers low-income women’s health and the well-being of their families.*

Research on the impact of restricting Medicaid coverage found that almost half of low-income women eligible for Medicaid faced obstacles accessing abortion care, averaging delays of 2-3 weeks among those who were delayed.<sup>2</sup> While abortion is a very safe procedure, health risks increase as the pregnancy progresses past the first trimester. Further, the research found that Medicaid-eligible women were significantly more likely to pay for the procedure with funds that would have been used for living expenses such as housing, child care, food and clothing.<sup>3</sup>

For decades, advocates have fought tirelessly to reverse this discriminatory law with little success. Each year the Hyde Amendment is debated in Congress and each year it passes with relative ease. At the state level, strategies to repeal restrictive Medicaid funding bans have shown mixed results. Thirteen states now fund medically-necessary abortions under court orders, and legal advocates continue to challenge state bans where possible.



States That Cover All or Most Medically Necessary Abortions - 17

States That Generally Restrict Medicaid Abortion Coverage to the Federal Hyde Amendment Requirements - 33

Source: State Policies in Brief: State Funding of Abortion under Medicaid. Alan Guttmacher Institute. March 1, 2004

### Barriers to Federally-Mandated Abortion Care under Medicaid

While advocates fight to repeal Medicaid-funding abortion bans at the state and federal levels, many women who do qualify for Medicaid-funded abortions are struggling to get coverage. Under the Hyde Amendment, all states are required to cover abortions under Medicaid in cases of rape, incest and life endangerment. However, as highlighted by the experience of advocates in Pennsylvania, women who fall under these circumstances – for whom getting a timely abortion is critically important – often face tremendous hardship accessing this care.

*Advocates can help low-income women obtain abortion coverage by removing practical barriers to care in the short-term, while remaining focused on the long-term goal of repealing the Hyde Amendment.*

Because of the lack of uniform reporting standards under Medicaid and the increasing reliance on managed care plans to coordinate care, it is extremely difficult to determine the current number of abortions covered in states that restrict Medicaid funding. When data have been reported, advocates find that many states cover only a handful of procedures each year, if any at all. According to NARAL Pro-Choice America, in 1999 nine states did not cover any abortions with Medicaid funds. Most other states that restrict Medicaid funding covered less than 10 procedures in that year.<sup>4</sup> Solely considering the 32,000 rape-related pregnancies in the United States each year, this is far below the expected need.<sup>5</sup>

In Pennsylvania, from July 2000 to April 2001, 243 women sought assistance obtaining Medicaid-covered abortions from CHOICE, a Pennsylvania reproductive health care advocacy organization. Some of those women secured Medicaid-funded abortions only after prolonged and difficult efforts by state advocates. Many ended up relying on private sources (typically a local abortion fund for loans or grants) after being unable to access coverage for abortion care under Medicaid.

Pennsylvania advocates, including the Women's Law Project, CHOICE, and Greater Philadelphia Women's Medical Fund, approached the Institute for Reproductive Health Access for support towards an effort to systematically identify and address barriers low-income women face when attempting to access federally mandated abortion care under the Hyde Amendment. By identifying reasons why women were unable to access care, the advocates were able to begin to remove those obstacles. Their efforts represent a model for advocates around the country to expand access to Medicaid-funded abortion care.

<sup>1</sup> Women's Health Policy Facts: Medicaid's Role for Women. Henry J. Kaiser Family Foundation. November 2000.

Medicaid: A Vital Source of Support for Family Planning Services. Prepared by The Alan Guttmacher Institute for Planned Parenthood Federation of America. March 2003.

<sup>2</sup> S.K. Henshaw and L.S. Wallach, "The Medicaid Cutoff and Abortion Services for the Poor. Family Planning Perspectives. 16:170, 1984.

<sup>3</sup> Ibid.

<sup>4</sup> NARAL & NARAL Foundation. Who Decides? A State-by-State Review of Abortion and Reproductive Rights. 10th Edition, 2001.

<sup>5</sup> Rape-related pregnancy: Estimates and descriptive characteristics from a national sample of women. Holmes, Melissa M., et al. Volume 175, Number 2, Am J Obstet Gynecol.

# The Pennsylvania Experience

Sue Frietsche, Staff Attorney, Women's Law Project

*A phone call came in from a young woman who was struggling to keep her voice under control. I listened patiently as she explained that she was pregnant as a result of rape, but her Medicaid managed care plan had just denied her coverage for an abortion because she hadn't reported the rape to the police. She said that she was getting desperate because she had no idea how to find the money to pay for the abortion on her own.*

I would love to say that this call was an anomaly, but it wasn't. Federal Medicaid restrictions limit abortion coverage to two cases only: when the pregnancy is the result of rape or incest, or when an abortion is necessary to save a woman's life. Passed in 1993, the Pennsylvania Abortion Control Act was even more restrictive than the federal Medicaid law. In order to qualify for a Medicaid-funded abortion in Pennsylvania, the woman had to personally report the rape to the police, including the name of the assailant, if known. In the case of life endangerment, two physicians had to certify that the woman would die without an abortion. We knew from the calls that came into the Women's Law Project, the CHOICE hotline and the Greater Philadelphia Women's Medical Fund that these additional requirements were often insurmountable barriers to Medicaid coverage for women. We challenged the rape reporting and second-physician certification requirements in federal court, and in 1995, we won. *See Elizabeth Blackwell Health Center for Women v. Knoll*, 61 F.3d 170 (3d Cir. 1995).

We thought that by removing such onerous restrictions, women in these serious circumstances would have timely access to Medicaid-funded abortion care, but we were wrong: desperate calls from women kept coming into our offices. We realized that there were a host of barriers preventing women who were eligible for Medicaid abortions from getting them. These cases only came into the Women's Law Project when they had reached the stage of absolute emergency – the woman's pregnancy was at 23 weeks, her last chance for an appointment was the next day, and her HMO just refused to preauthorize the procedure.

*At first, we dealt with each case on an emergency basis, but came to realize that we needed to address these diffuse problems pro-actively and find a systemic solution to remedy them.*

At first, we dealt with each case on an emergency basis, but came to realize that we needed to address these diffuse problems pro-actively and find a systemic solution to remedy them. We needed to develop a plan to specifically tackle the obstacles to abortion coverage under Medicaid.

Our first step was to meet with abortion providers from across Pennsylvania to talk to them about what was stopping women from accessing Medicaid abortions. *We discovered breakdowns at every stage of the process.* Some of the obstacles we identified were:

- The Medicaid "MA-3" forms, filled out by providers and women to show eligibility for a Medicaid abortion, were confusing and intimidating. They required survivors to know the legal distinction between rape and incest, and to give the date of the assault that resulted in their pregnancy (an impossibility for some incest survivors who had been assaulted repeatedly); the forms implied that only the doctor providing the abortion could complete the certification; and, they made the survivor check off whether or not she had reported the crime to the police, without ever informing her that a police report was not necessary.
- Sadly, many doctors did not believe women who told them they had become pregnant from rape. Some doctors even imposed a quota on themselves, setting an arbitrary limit on the number of abortions they were willing to provide for rape survivors.
- Some providers would not accept MA-3 forms from certain HMOs; the HMOs were not familiar with the legal requirements governing Medicaid abortion.
- Women who received fee-for-service care, as opposed to care offered through a managed care plan, had absolutely no access to abortion services.
- There was confusion about what constituted a "life threat" – did it include only physical threats, or could a threat of suicide be taken into account?
- Many women, even when difficulties with their Medicaid coverage were resolved, were unable to afford the costs of travel to the limited number of abortion providers in the state, or to out-of-state providers who were sometimes their only option.

These meetings clarified the need for advocacy to ensure that the Medicaid coverage we thought we had won back in 1995 was actually

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going to benefit women. We mapped out the most serious obstacles women were facing, and developed a long-term plan for removing those obstacles. In 2001, we applied for financial and technical support from the Institute for Reproductive Health Access, and used this support to form a small working group that met regularly for several years, the sole purpose of which was to eliminate the barriers to Medicaid-funded abortion. Their discussions resulted in several important steps forward:

### **Improving Public Understanding**

We started by tackling the dearth of accurate information. We researched and wrote brochures explaining when Medicaid would cover abortion in Pennsylvania: one on eligibility for rape and incest survivors, one on life endangerment, and one general brochure for service providers and advocates. We enlisted the invaluable assistance of Community Legal Services in Philadelphia, which contributed a wealth of expertise on Medicaid. These brochures were posted on the Women's Law Project website and distributed to 10,000 abortion providers, family planning agencies, rape crisis centers, domestic violence shelters, emergency rooms, social workers, welfare advocates, and women's activists around the state.

### **Gaining Support of Public Officials**

The election of pro-choice Governor Ed Rendell provided us with newfound momentum, as the new administration swept away decades of hostile reproductive health policies. We redrafted the intimidating Medicaid forms and met with the Department of Public Welfare (DPW) to see if they would approve the streamlined forms – a process still ongoing, but which we hope to complete soon. At our urging, DPW also designated a trouble-shooter to whom we could turn for help in solving problems with particular cases. The assistance we received has ranged from confirming that a client was actually enrolled in the Medicaid program, to faxing departmental guidances about abortion eligibility to skeptical HMOs, and to expediting a client's enrollment in the Medicaid system.

### **Training Providers**

One of the most positive outcomes of our communication with the administration was their offer to help train interested abortion providers on how to bill for their services. With this guidance, and through regular communication with providers around the state, we were able to convince more providers to accept Medicaid reimbursement, thereby expanding options for low-income women.

### **Getting Women to Providers**

Having addressed many of the most glaring obstacles to Medicaid-funded abortion care, we turned our attention to a more peripheral, but just as critical, issue: women's inability to travel to get an abortion once covered

by Medicaid. We found out that Pennsylvania's Medicaid program covers transportation to and from any Medicaid covered service, through the county-based Medical Assistance Transportation Program (MATP). There are 67 counties in Pennsylvania with 67 different sets of instructions for accessing this program. We educated ourselves and providers about how to use this system, and built relationships with some of the county-level welfare supervisors who were able to intervene to solve eligibility problems and answer questions for us when time was of the essence. We have yet to use the MATP for long-distance travel out-of-state, but are gratified that if and when the need arises, we will have a foundation of information from which to advocate for coverage.

Trying to convince a huge bureaucracy to sensitively and promptly provide a stigmatized service felt like a daunting task at times, but it was worth every minute we invested in it. By taking the time to identify and systematically address barriers to this vital and time-sensitive care, we were able to make great strides in helping Pennsylvania women. We achieved important and encouraging reforms, and know for certain that we rescued many women during dire times of need. Most gratifying of all, the project helped to change attitudes toward rape and incest survivors, brought light to navigating the Medicaid system, and even transformed our own expectations of ourselves. Now when a problem arises with abortion and Medicaid, we expect that we can and will solve it, and the patient will receive the medical care to which she is entitled.

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Just recently, a call came into our office that would have given me nightmares a few years ago. It was from an indigent woman in her mid-second trimester of pregnancy who was not even enrolled yet in the Medicaid system (a process that can take as long as a month). She had an appointment for an abortion in New York in a matter of days, and was afraid that if she broke that appointment, she would not be able to get another in time. It took only a few phone calls to welfare officials, and the assistance of the Greater Philadelphia Women's Medical Fund and the CHOICE hotline, to get her eligibility confirmed, her Medicaid card activated, and arrangements made with activists in New York to help her while she was there – a world of difference from the chaos we had become accustomed to before the Medicaid project taught us to expect more.

# Actions You Can Take in Your State to Expand Access to Medicaid-Funded Abortion Care

## Replicating the Pennsylvania Model

The availability and accessibility of Medicaid-funded abortion varies state-to-state. Yet in almost all states with Hyde Amendment restrictions, only a small number of women – sometimes none – are being covered for abortion care under Medicaid in cases of rape, incest and life endangerment. Low-income women are being denied coverage even though federal law requires state Medicaid programs to pay for abortion care in these limited circumstances. Onerous requirements, misleading reimbursement procedures, and misinformed managed care plans are just some of the most commonly identified obstacles preventing appropriate and timely Medicaid-funded abortion coverage. By working to identify local barriers to this care, advocates can take measurable steps to remove these obstacles.

- 1. Find out if women in your state have adequate access to Medicaid-funded abortions.** Are women able to get coverage in cases of rape, incest and life-endangerment? If not, what are the obstacles? Talk to local abortion funds, abortion providers, legal service organizations, community health care clinics, and health care advocates to learn more.
- 2. Document the problem.** A critical part of establishing unmet need is gathering stories of women who have been delayed getting abortion care or who were unable to get Medicaid coverage. Stories will be a powerful tool when you approach public officials, allies and the media. Advocates should also collect state data on the number of women who rely on Medicaid for health coverage, and how many abortion procedures are covered each year.
- 3. Educate women and abortion providers.** Develop factsheets or brochures that outline a woman's right to access Medicaid-funded abortion care. Create materials for abortion and family planning providers, as well as providers of domestic violence and rape-crisis services, that explain the Medicaid reimbursement process and provide resources for assistance.
- 4. Research state law and policies.** It is important to understand your state's policies in regard to provision and reimbursement of abortion care under Medicaid. For example, is the state requiring onerous information in order for women to access care, such as requiring women to report incidents of sexual assault to law enforcement? Who is responsible for educating Medicaid managed care consumers about their right to abortion care – the state or the managed care plan?
- 5. Work with public officials.** Advocates can work with public officials to remove obstacles to abortion care. Possible strategies include asking the state to notify plans and providers about women's rights to abortion coverage, or designating a point person in the state Medicaid program to help providers get reimbursement when they face barriers.

### The Institute for Reproductive Health Access can help!

Contact the Institute at (212) 343-0114 or [institute@prochoice.ny.org](mailto:institute@prochoice.ny.org) for more information on how your organization can expand access to Medicaid-funded abortion.

#### Who Else Can Help?

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