Invited paper

Out of Time and Out of Pocket: Experiences of Women Seeking State-Subsidized Insurance for Abortion Care in Massachusetts

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\textbf{Abstract}

\textbf{Background:} Massachusetts has implemented reforms aimed at providing universal health care coverage and covers abortion through subsidized state insurance programs. Three Massachusetts abortion funds evaluated their referral processes for low-income women from April to October 2010 to learn about women’s experiences applying for subsidized insurance and to identify barriers to obtaining insurance or its use for abortion services.

\textbf{Methods:} Follow-up interviews were conducted with 39 low-income women thought eligible for subsidized insurance at least 1 month after their initial contact with the funds.

\textbf{Results:} Health insurance literacy was low, and participants reported confusion distinguishing between levels of subsidized insurance. The process of applying for subsidized insurance delayed a substantial proportion of procedures. More than two thirds of the women who applied for state coverage had become insured or expected to become insured shortly, but only one third of respondents who applied were able to secure insurance in time for their abortion care. Two women were unable to obtain abortions as a result of delays. Delays also limited low-income women’s ability to obtain medication abortion.

\textbf{Conclusion:} This analysis suggests that the process for enrolling in subsidized insurance does not currently meet the goal of providing women with coverage for abortion care (and other health needs) in a timely way. Systemic improvements are needed to ensure that enrollments are processed quickly and disruptions in coverage are minimized. Information resources should be developed to help women and their families understand health insurance and coverage of services.

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\textbf{Background}

The literature firmly establishes that inadequate public funding for abortion disproportionately affects poor women (Boonstra, 2007; Levine, Trainor, & Zimmerman, 1996). Difficulties securing financial support are also associated with delays in obtaining abortions (Drey et al., 2006; Finer, Frohwirth, Dauphinee, Singh, Moore, 2006). Women who obtain second-trimester abortions tend to be poor, young, and disproportionately women of color (Boonstra & Sonfield, 2000, p. 10). Delaying abortion care is a matter of concern because, although abortion is very safe, the risk to women increases with gestational age (Bartlett, 2004).

The effect that public funding has on the number of abortions has been the subject of considerable debate (Boonstra, 2007; Cook, Parnell, Moore, Pagnini, 1999; Henshaw & Wallisch, 1984; Morgan & Parnell 2002). Whelan (2010) suggests that universal health insurance in Massachusetts and the coverage of low-income adults through subsidized insurance programs, in particular, did not increase abortion rates, but may have actually contributed to declining abortion rates there.

As a model for national health care reform, Massachusetts provides a window into how abortion funding under universal health insurance might look. Massachusetts’s reforms included expanding eligibility for MassHealth (Medicaid) and establishing
Commonwealth Care, a means-tested subsidized insurance program for low-income residents whose household incomes exceed the threshold for MassHealth. These initiatives resulted in a statewide uninsurance rate of 2.7% in 2009; the uninsurance rate among nonelderly adults with family incomes less than 300% of the federal poverty level (FPL) was 6.2% and 7.7% among those without an adult worker in the family (Long & Phadera, 2009, p. 2–3). Massachusetts is 1 of 17 states that cover abortion through state Medicaid funds (Towey, Poggi, & Roth, 2005); abortion care is also covered by several other insurance programs subsidized by the Commonwealth.1 Medicaid pays for 27% of abortions in these states compared with less than 1% in non-Medicaid states (Henshaw & Finer, 2003). Yet we might expect this figure to be higher: Jones, Finer, and Singh (2010) found that more than half of all abortions are obtained by women with family incomes below 200% of the FPL.

Abortion funds are typically small, regional, philanthropic organizations that provide direct funding to women who would otherwise be unable to afford abortion care. Anecdotal evidence from the three Massachusetts abortion funds—the Eastern Massachusetts Abortion Fund, the Jane Fund of Central Massachusetts, and the Abortion Rights Fund of Western Massachusetts—suggests that, despite the Commonwealth’s formal commitment to comprehensive reproductive health care, apparently eligible women have difficulty obtaining MassHealth coverage for abortion care.

Methods

This paper reports information gathered by the abortion funds from April to October 2010 through systematic, qualitative interviews with women they referred to subsidized insurance programs. The response rate is low, and the sample is neither representative nor powered for statistical significance. However, this exploratory investigation identified interesting themes that may inform future research.

Abortion fund volunteers asked women they referred to subsidized insurance programs to participate in a follow-up interview by telephone approximately 1 month after their initial contact. Funds determine eligibility for state insurance programs based on clients’ self-reports: clients younger than 18 and non-English speakers were not invited to participate. Clients were informed that participating in this follow-up call would not affect their ability to receive a grant from the fund, their enrollment in subsidized insurance, or their health care services. Clients were informed that their experiences could be used for advocacy purposes and that their identities would be protected by changing their names and personal details.

Ninety-one eligible women agreed to participate, 52 of whom either could not be reached for follow-up at the numbers provided (37) or who declined to participate when they were called (15); the response rate was 43%. Thirty-nine follow-up interviews were completed with English-speaking women who met the eligibility requirements for subsidized insurance programs in Massachusetts: Women whose household income is less than 300% FPL who are uninsured, who are U.S. citizens or have been permanent residents for more than 5 years, and who are Massachusetts residents.

Follow-up interviews covered current insurance status; pregnancy outcome; if terminated, date and funding source; if enrolled in subsidized insurance, date of activation, mode of enrollment, and experiences related to enrollment process; billing experience; and conversation notes. The lead author used SPSS (SPSS, Inc., Chicago, IL) to calculate descriptive statistics and conducted thematic analysis using both a priori categories and codes and inductive analysis techniques. The University of Cincinnati Institutional Review Board approved the use of data for publication.

Participants reported household incomes from paid work from $0 to $60,000 a year, with a mean of $11,971. Reported ages ranged from 18 to 43, with a mean of 24 years old. Sixteen respondents lived in eastern Massachusetts, 13 in central Massachusetts, and 10 in western Massachusetts. Fourteen lived in households with children.

Results

A theme common to all interviews was the difficulty of navigating the application process for subsidized insurance; this was particularly pronounced among younger women. Women reported difficulty obtaining accurate information both about subsidized insurance in general and their applications in particular. Follow-up interviews provided evidence of low insurance literacy; respondents often had difficulty naming their insurance plans and were unable to distinguish between different levels of subsidized insurance, both between plans (e.g., Commonwealth Care and MassHealth) and within plans (different types of MassHealth). Recognizing these distinctions was often crucial because only some types of MassHealth cover abortion. A few women reported that concerns about abortion stigma caused them to avoid mentioning their pregnancy or their intention to obtain an abortion to state employees and insurance advocates, compounding their difficulties in navigating the application process.

Women also reported difficulty knowing whether their insurance was active and complained that staying enrolled in these plans was challenging. Women indicated that information from the state insurance system was confusing and often out of date by the time notifications reached them, which is consistent with other research (Bessett et al., 2010). Two women reported that they had been told their applications for MassHealth plans had been approved but were unsure if they were currently insured or when their enrollment would be reactivated. Many women reported difficulty staying enrolled on subsidized insurance before they sought funding for abortion; they had been disenrolled from subsidized plans because of (often temporary) changes in employment, not receiving reactivation forms owing to address changes, or what they described as administrative error on the part of the Commonwealth.

Thirty-six of the 39 women interviewed terminated their pregnancies, 1 woman miscarried, and 2 women intended to carry their pregnancies to term at the time of follow-up. All 39 were provided with contact information to enroll in subsidized insurance, and 32 women filed formal applications. Seven women did not apply for subsidized insurance: Two hoped to obtain insurance through their employers, two had particularly urgent health needs, two decided not to apply after speaking with enrollment representatives, and one woman said her previous experience with MassHealth led her to believe that it would not be activated in time. Nonetheless, all seven women who did not file terminated their pregnancies.

Two thirds of the 32 women who applied for subsidized insurance were insured or approved for insurance at the time of
the follow-up interview (Table 1). Of these, 10 secured coverage from state-subsidized insurance for their abortions (Table 2). Another 10 women who paid for their abortions in cash or a combination of cash and abortion fund grants while waiting for their applications to be processed were later enrolled in subsidized insurance programs or accepted pending activation. One woman miscarried and was subsequently enrolled in subsidized insurance. Nine women were pursuing subsidized insurance at the time of follow-up, although they had already had abortions. The two women who continued their pregnancies had applied for insurance, but were still uninsured or unsure about their status at the time of the follow-up interview.

Although fewer than half of the women who applied for subsidized insurance secured funding for their abortions, most reported that abortion fund staff and the nonprofit insurance advocates with whom the funds collaborated provided structure to an application process that had previously seemed baffling. Many women commented on how professional and helpful the insurance advocates were and that they had been unaware of the resources available to help them with their insurance. Another theme of the interviews centered on the abortion as a defining moment in the women’s lives that clarified their priorities and the need to take care of themselves and their health in the future. Women who were able to secure insurance coverage for their abortions reported high satisfaction with coverage provided and, once insured, experienced few barriers using their state-subsidized insurance for abortion care.

Applying for subsidized insurance was also associated with long delays. Although pregnant women’s applications are supposed to be expedited, it often took several weeks to become enrolled even if everything went smoothly. Women reported errors, missing forms, or lost supporting documents, which extended the application period for many. More than half the women interviewed reported delaying their abortions while they tried to secure subsidized insurance; this caused considerable stress as the women tried to manage symptoms, often without disclosing the pregnancy, and worried about being able to afford a termination if the pregnancy continued too long. This delay had more severe consequences for a few women: Ariana, whose procedure was delayed by 3 weeks while waiting to be enrolled on MassHealth, reported having to travel an hour and a half to see a new provider, which increased the cost of travel and put her into the early second trimester. MassHealth ultimately covered Ariana’s abortion. Lana, a 19-year-old who first contacted the funds at 23 weeks’ gestation, described “timing out” of an in-state surgical abortion when she was unable to become enrolled right away; nor would MassHealth cover abortion care provided by out-of-state providers. Lana ultimately completed her pregnancy, intending to give the baby up for adoption, but explained that she was very disappointed by MassHealth, “If I had had MassHealth, I would have gone right ahead and had the procedure.” Both of these women were subjected to additional stress and health risks by the lack of timely coverage.

Delays also limited women’s ability to obtain medication abortion. As medication abortion is typically provided through the 63rd day after the woman’s last menstrual period, several women reported considerable anxiety that they might not obtain insurance in time. Although at least one woman was able to obtain and use Commonwealth Care for a medication abortion in a timely way, the approaching deadline prompted abortion funds to provide grants to at least two desperate women. Both women were later deemed eligible for MassHealth, suggesting that the costs for abortion should have been covered by insurance. A third woman, Jane, aged 18, reported being so fearful of “surgical abortion” that she ultimately decided to continue her pregnancy after her struggles with MassHealth put her past the limit for medication abortion. Jane first applied for insurance at 6 weeks’ gestation; by the time of follow-up 37 days later, she was still unsure if she had been approved for MassHealth. The delays caused by attempts to enroll in subsidized insurance had a disproportionate impact on women who sought medication abortion, forcing them to pay out of pocket or placing their preferred method for termination out of reach.

**Discussion**

The sample for this qualitative project came from a very particular universe: Women who found their way to abortion funds. Women who were already on subsidized insurance, who were referred to insurance by abortion clinics, or who sought insurance independently may have had different experiences. We speculate that women who are already mothers may already be enrolled in state-subsidized insurance as a result of increased familiarity with the system or initiatives to increase the eligibility of mothers of young children; this may explain why our sample contains fewer households with children (36%) than might be expected from national studies (Jones et al., 2010). The two women who intended to carry their pregnancies to term after failing to obtain coverage for abortion services did not benefit from targeted programs, such as prenatal-only plans with expedited application processes; we speculate that their applications were tracked for standard coverage required for abortion care and that they were unaware that they could obtain coverage for limited services sooner.

### Table 1
**Women’s Insurance Status and Type at Time of Follow-up, by Pregnancy Outcome**

<table>
<thead>
<tr>
<th>Insurance Status and Type</th>
<th>Pregnancy Outcome</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Abortion</td>
<td>Continued Pregnancy</td>
</tr>
<tr>
<td>Uninsured</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Unsure if insured</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MassHealth</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Employer plan</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Insurance pending</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MassHealth</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Employer plan</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Insured</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MassHealth</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>Commonwealth Care</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>2</td>
</tr>
</tbody>
</table>

### Table 2
**Reported Payment Sources for Abortion**

<table>
<thead>
<tr>
<th>Payment Source</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>MassHealth</td>
<td>9</td>
</tr>
<tr>
<td>Commonwealth Care</td>
<td>1</td>
</tr>
<tr>
<td>Grant from abortion fund and cash</td>
<td>19</td>
</tr>
<tr>
<td>Cash, but no grant</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
</tr>
</tbody>
</table>
This paper reports the experiences of women who could be contacted for follow-up interviews. Women who could not be reached for interviews because of disconnected numbers (71%) are likely the most vulnerable of the initial sample, with low housing security and unreliable contact information. Because stable contact information is required for subsidized insurance, it is likely that the insurance outcomes for women who could not be reached are even less promising than for those described herein.

Women in this study expressed some uncertainty about their insurance status and about dates of all kinds, including insurance activation, abortion date, and gestational age at the time of abortion, so their self-reported insurance status and estimates of delays may be inaccurate. Evidence of information barriers was further illustrated by the small number of applications that were approved in a matter of days once women were connected with insurance advocates. Often these were women who had previously been dropped from subsidized insurance for administrative reasons that could be corrected easily once the reason for the disruption was understood.

Although four women complained that they had not received sufficient information from the abortion funds to apply for subsidized insurance, the remainder described their contact with funds as providing a gateway to securing subsidized insurance, even when the procedure itself was not covered. The crisis of an unwanted pregnancy served as an impetus to become insured, and they located unanticipated assistance from funds. Although deeply disappointed when their goal of obtaining abortion coverage was not met, all of the women who applied continued to pursue subsidized insurance.2

Conclusion

Massachusetts leads the country in insuring its citizens, has relatively expansive eligibility criteria for subsidized insurance, and is among the minority of states that provide subsidized state insurance for abortion services. Some might expect that, in this policy context, women would not encounter barriers to coverage for abortion.2 The findings reported herein challenge that expectation, however; women do, in fact, experience difficulties in obtaining state insurance, and these difficulties impeded women’s ability to obtain coverage for time-sensitive procedures and, in at least two cases, the pregnancy outcome itself.

Delays in enrollment for subsidized insurance led women to postpone abortion care, sometimes by many weeks, and ultimately transferred the economic burden from the state to women and abortion funds. We estimate that poor women and abortion funds paid for at least 10 abortions that ought to have been covered by the Commonwealth, but that number may be as high as 21 in this small sample. Unnecessary delays should also be a matter of concern to policy makers in Medicaid states, because procedures at later gestational ages are more expensive and delays may increase costs to the state.

The intangible costs of enrollment delays must also be taken into account. In two cases, the delays meant that women were unable to obtain the abortions they sought. These two cases also demonstrate that failing to provide all pregnant women with presumptive eligibility and expedited access to care may constrain their ability to obtain not only abortion services, but also services for pregnancies if their applications are not tracked correctly. Given that so many women reported being dropped from subsidized insurance before becoming pregnant, strengthening renewal mechanisms would also likely eliminate delays. Not only would this improve women’s ability to secure the pregnancy outcome they want, but it might also reduce the risk of an unwanted pregnancy through better and more regular access to more effective contraceptives.

The findings of this research suggest that enrollment procedures for subsidized insurance in the Commonwealth need improvement. They also suggest that improving information services, educating women in health insurance literacy, and supporting health insurance advocates must be top priorities for states as they move toward universal coverage under national health care reform.

Acknowledgments

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References


2 Four of the women who had not applied for subsidized insurance indicated that they intended to apply for subsidized insurance in the future, based on information they learned from the referrals.

3 We thank reviewer #1 for this point.
Author Descriptions

Danielle Bessett, PhD, was an Ellertson Fellow from 2008–2010 and is now Assistant Professor of Sociology at the University of Cincinnati, Cincinnati, Ohio. Her research interests are in medical and family sociology, focusing on sexual and reproductive health issues and inequality.

Katey Gorski studies Government at Smith College in Northampton, Massachusetts, and expects to receive her BA in the spring of 2011. She interns with the Abortion Rights Fund of Western Massachusetts.

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