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COMMENTARY

INSURED WOMEN AND PAYMENT FOR ELECTIVE ABORTION

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Of the roughly 1.3 million abortion procedures performed in the United States in 2003, only 25% of patients used their health insurance to pay for the medical expenses, even though 82% of all women between the ages 18 and 64 had some form of insurance that year (Finer & Henshaw, 2003; Kaiser Family Foundation, 2004). This finding is interesting in light of another study, which found that 87% of a nationally representative sample of 205 private health insurers covered abortion services by 2002, an increase from 70% of insurers sampled in 1993 (Sonfield, Gold, Frost, & Darroch, 2004). This evidence suggests that women who have health insurance and pay out of pocket (OOP) for abortion may be encountering obstacles to using health insurance for abortion procedures, an issue that has not yet been fully examined in the prior research literature. Our objective was to examine the evidence regarding insured women's OOP payment for abortion. We first consider possible reasons for women's uncertainty about insurance coverage for abortion procedures and the impact that privacy concerns, abortion clinics, and a limited decision-making timeframe have on this uncertainty. We then compare the abortion case study to another medical procedure, *BRCA* genetic screening, where some insured patients choose to pay OOP whereas others do not for these procedures. We conclude that the limited evidence suggests that there are barriers to women's use of their health insurance plans for abortion procedures that should be addressed.

Uncertainty About Coverage

Limited data suggest that women obtaining an elective abortion and paying OOP are likely to be uncertain about insurance coverage for elective abortion procedures. Our work found that among a convenience sample of 212 women seeking medication abortion care in 5 different clinical settings, three quarters reported having health insurance and nearly all paid OOP for the procedure rather than have their insurer cover the costs (Van Bebber, Phillips, Weitz, Gould, & Stewart, 2006). In the same study, we found that 50% of surveyed patients did not know about their insurance plan's policies for covering elective abortion procedures (Van Bebber et al., 2006). These findings suggest that a key reason for why women with health insurance pay OOP for abortion procedures is their uncertainty about their insurers' policies.

One reason for women's uncertainty is that coverage policies differ between 1 employer and another and between 1 state and another's governmental regulations. Private health insurance coverage for abortion procedures is complicated by several factors, including individual employers' ability to delete abortion services when purchasing insurance coverage from health care insurers. Moreover, 4 states (Idaho, Kentucky, Missouri, and North Dakota) mandate that abortion coverage be limited to life endangerment cases so that additional abortion coverage is available only through additional premium costs (Guttmacher

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Institute, 2007). For individuals covered by public health insurance (e.g., Medicaid and state/federal employees' insurance plans), one of the key barriers to insurance coverage is the 1976 Hyde amendment, which prohibits federal dollars from being spent on abortion procedures. As a result, Medicaid covers abortion procedures only in the 17 states that fill the federal government's void with their own state funds (Guttmacher Institute, 2006). There is, therefore, great variability in coverage depending on employer and state policies.

Privacy Concerns

In addition to variability in insurers' coverage for abortion procedures, our review of the literature suggests other reasons for patients' uncertainty over using insurance. Privacy concerns were identified as 1 factor for patients paying OOP. For elective abortion care patients, privacy is an important issue for minors covered by parents' insurance plans but who do not want their parents to find out about the procedure (Sugerman et al., 2000). Because one quarter of insured women are covered through their spouse's plan (Kaiser Family Foundation, 2004), however, privacy concerns about using insurance may extend to women beyond the adolescent age group.

Abortion Clinics

Receiving care at specialized settings outside one's usual health provider setting (e.g., physicians' office or hospital) is another factor contributing to patients' uncertainty about insurance coverage for abortion procedures. One study estimated that specialized abortion clinics (defined as providers where more than half of patients come in for an abortion) provided 71% of all US abortions in 2000 (Finer & Henshaw, 2003). Another study found, however, that specialized abortion providers may not accept payment via insurance for various reasons (Gemperli et al., 2005). Furthermore, one third of reproductive age women in the United States live in counties without abortion care facilities (Henshaw & Finer, 2003). Given this limited provider availability, women may not be able to find a provider that accepts any insurance or their particular insurance plan.

Limited Timeframe

Unlike other medical procedures, where patients may seek out information about their insurance plan and provider to make an informed choice, the timing of the decision for women seeking an abortion has a significant impact on treatment options and availability of willing providers. Surgical and medical options are available through 9 weeks of pregnancy, but women only have the surgical option 9 weeks after gestation (Grimes & Creinin, 2004; Henshaw & Finer, 2003). After 24 weeks of gestation, women cannot obtain an elective abortion procedure. This limited timeframe for many abortion patients is furthermore compounded by emotional stress that may make information gathering even more difficult.

Comparison With *BRCA* Screening

The screening test for breast cancer serves as a good comparison to abortion patients who pay OOP instead of using their insurance. As a tool for detecting the presence of altered *BRCA1* and *BRCA2* genes and predicting susceptibility to breast cancer, Myriad Genetics, Inc., introduced the genetic screening test to patients in 1996 (Lee, Berhardt, & Helzlsouer, 2002). For individuals who are likely to carry the altered *BRCA* gene, their insurers will likely cover the medical expenses. For individuals not meeting insurance plan's criteria or choosing not to use insurance, the only other option is to pay OOP. Although prior literature does not measure the percentage of *BRCA* genetic screening patients who pay OOP, surveys of average-risk women suggests that >40% of patients, likely the "worried well," were interested in the screening even if they had to pay OOP for the procedure (Gwyn, Vernon, & Conoley, 2003; Ludman, Curry, Hoffman, & Taplin, 1999).

Like abortion patients, patients wishing to undergo a *BRCA* screening do not necessarily have to visit their usual medical provider. Instead, genetic testing services by web-based companies such as Dnadirect.com (2006) offer *BRCA* genetic screening services for individuals who wish to test at home. What differs significantly between *BRCA* genetic screening and abortion procedures then is the availability and accessibility of information about insurance coverage policies. In contrast with abortion patients, who have little to no information on coverage policies, both the *BRCA* genetic screening test manufacturer and genetic testing services offer information on and assistance to patients about using insurance to pay for the genetic screening. On their web sites, the manufacturer and genetic testing services describe the criteria that patients must meet for insurers to pay for the screening, as well as a patient support telephone number to assist with insurance questions. Women wishing to undergo a *BRCA* genetic screening therefore have information on insurance coverage from multiple sources.

There is 1 potential reason for this difference between abortion and *BRCA* genetic screening cases. The manufacturer and genetic testing service providers as for-profit entities may have a financial interest in

facilitating patients using their insurance plans to cover the relatively expensive *BRCA* genetic screening costs, which totaled $2,057 according to one study (Lawrence et al., 2001). In contrast, Danco Laboratories, whose sole product is mifepristone, is a women's health pharmaceutical company that obtained the exclusive licensing arrangements to mifepristone from the Population Council, a private nonprofit research organization (National Abortion Federation, 2007). Danco offers insurance and reimbursement information on their web site, not to the abortion patient who pays $306 for the procedure (Afable-Munsuz et al., 2007; Van Bebber et al., 2006), but rather to physicians, suggesting a different "business model" from that of genetic screening. Thus, demand for abortion services are not necessarily consumer driven, but rather are driven by the supply of providers willing to offer this abortion option.

Recommendations and Conclusion

Our review of the current literature suggests that there are many potential reasons why women do not use their insurance plans for abortion procedures. The variability in coverage policies among providers, employers, and states may make it difficult for women to know whether they can use insurance to pay for the procedure. This uncertain situation is further complicated by a limited and potentially stressful timeframe for the women to find a provider and undergo the procedure. As the comparison to *BRCA* genetic screening suggests, information on insurance coverage policies may not be as readily available for abortion patients compared with other medical procedures.

More empirical research among women seeking abortion care may shed light on the extent to which provider availability, financial barriers, and insurance coverage play a significant role in limiting women's access to abortion care. Specifically, future studies should collect evidence-based data on the following: 1) the percent of private insurers who have explicit abortion coverage and 2) among insured women seeking abortion care, the percent that use insurance to pay for it. As our review indicates thus far, improving the information given to patients on insurance coverage and/or systematizing ways for providers to help patients to access insurance coverage are potential ways to improve access to abortion care. Through a concerted effort by insurers and providers, abortion patients may become more informed about insurance coverage policies and not face the financial burden of paying OOP.

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