Health Advocate

E-Newsletter of the National Health Law Program

Volume 43 November 2015

Reproductive Health Data and Accountability Project

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Key Resources

Improving Coverage: Using State Law to Maximize Access to Family Planning and Abortion Services

Coming in December's *Health Advocate*:

Litigation Round-Up

Introduction

As millions of individuals gain health coverage due to the Affordable Care Act (ACA), many continue to struggle with access to comprehensive reproductive health care, which includes family planning and abortion services. The National Health Law Program's Reproductive Health Data and Accountability Project has established systems to collect, analyze, and utilize data on access barriers to family planning and abortion services in public programs, such as Medicaid and the Children's Health Insurance Program (CHIP), and in private health insurance. In collaboration with the Advancing New Standards in Reproductive Health (ANSIRH) program at the University of California, San Francisco (UCSF), NHeLP is working with approximately 38 provider, clinic administrator, and consumer advocate partners in 33 states. The Data Project is identifying, addressing, and removing obstacles that prevent individuals from obtaining the services and supplies needed to achieve their reproductive life goals with dignity.

Background

Women consider a number of factors when determining whether to become or remain pregnant, including age, educational goals, economic situation, the presence of a partner and/or other children, medical conditions, mental health, and whether they are taking medications that are contraindicated for pregnancy. In 2014, there were 62 million women of reproductive age (aged 15-44) in the United States. Over 70% of these women were at risk of unintended pregnancy, meaning that they were sexually active with a male, capable of becoming pregnant, and neither pregnant nor seeking to become pregnant. Each year, half of the pregnancies in the United States are unintended (unwanted or mistimed). By age 45, more than half of all women in the United States have experienced an unintended pregnancy, and three in 10 have had an abortion.

Unintended pregnancy rates are highest among poor and low-income women, women aged 18-24, cohabiting women, and women of color. Low-income women are the least likely to have the resources to obtain reliable methods of family planning, and yet, they are most likely to be impacted negatively by unintended pregnancy. They are also denied coverage for abortion services due to the federal "Hyde Amendment," an amendment to the annual U.S. Department of Health & Human Services appropriations bill, which severely limits federal funding for abortions to cases of life endangerment or pregnancies due to rape or incest.

Access to abortion and family planning services in the states

To make effective decisions on whether and when to become or stay pregnant, individuals need access to family planning and abortion services. For many individuals, however, cost is a barrier. Enrolling in private health insurance coverage or in Medicaid can remove some of these financial barriers and help individuals access necessary health care services.

Coverage alone, however, does not guarantee access to services. Women continue to confront barriers such as lack of confidentiality, religious refusals by providers, low reimbursement rates, the expansion of managed care, and problematic insurance practices that limit access to covered services through medical management techniques. Maximizing the potential of private health insurance and Medicaid requires strong laws and policies—on the books and in practice—that ensure individuals have comprehensive, affordable coverage and timely access to family planning and abortion services. Below are some examples of barriers to family planning and abortion care that women face.

Abortion

Individuals enrolled in California's Medi-Cal program may go out-of-network for abortion services to any Medi-Cal provider of their choice, regardless of whether or not the provider is part of their managed care network, for any reason, and without prior authorization or medical justification. Yet, data gathered through the Data Project shows that individuals seeking abortion care from an out-of-network provider are sometimes subject to prior authorization requirements, which can delay or even completely impede access to care. Good laws like California's cannot promote access unless they are actually enforced.

In other states, Medicaid enrollees have difficulty obtaining Medicaid coverage of abortion. Although federal law severely restricts federal funding of abortion, state Medicaid programs must cover abortions for which federal funding is available, *i.e.* in cases of rape, incest, and life endangerment. States can use their own funds to cover all abortions, regardless of whether federal funding is available, but unfortunately most do not.

Federal law permits states to impose reporting or documentation requirements on Medicaid enrollees or providers to confirm that a pregnancy was the result of rape or incest. However, federal Medicaid guidelines require that states waive any state-imposed reporting or documentation requirements and consider the abortion procedure reimbursable if the "treating physician certifies that in his or her professional opinion, the patient was unable, for physical or psychological reasons, to comply with the [reporting] requirements."[1] Yet, the Data Project shows that in at least one state, Pennsylvania, some providers do not understand that reporting requirements can be waived. Further, some Pennsylvania Medicaid enrollees are told that Medicaid will cover their abortions only if they report their rape to law enforcement—even though providers can waive such reporting or documentation requirements in qualifying circumstances.

Family planning

Federal Medicaid law requires states to cover "family planning services and supplies" without cost-sharing. Utilization controls such as prior authorization, quantity limits, and step therapy ("try and fail") are at the core of managed care. In general, federal rules allow states and plans to place "appropriate limits on a service . . . on the basis of criteria applied under the State plan, such as medical necessity" or "[f]or the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose . . . ."[2] However, these controls

[1] *See* Letter from Sally K. Richardson, Dir., Ctr. for Medicaid & State Ops., Health Care Financing Admin., to State Medicaid Dirs. (Dec. 28, 1993).
[2] 42 C.F.R. § 438.210(a)(3)(iii)(B); *see also id.* § 438.210(b)-(d) (regarding prior authorization).

are inappropriate in family planning. Federal law requires states to ensure that Medicaid enrollees are "free from coercion and mental pressure and free to choose the method of family planning to be used."[3] Yet, in some states, Medicaid managed care plans are permitted to impose utilization controls on family planning services and supplies. For example, a plan that covered Medicaid enrollees in New Hampshire used prior authorization and step therapy to restrict access to hormonal IUDs. A California plan required women to "try" oral contraceptives for three months and "fail" before they could access the contraceptive ring. Women who did not meet the step therapy criteria could not access the contraceptive method of their choice.

Conclusion

The systematic collection of data on the specific obstacles that both providers and patients face in providing and accessing reproductive health services is surfacing the hidden barriers in public and private insurance that undermine access to critical services. NHeLP and allies are working together to develop and implement strategic advocacy efforts to address barriers and improve access to services. For more information about the Reproductive Health Data and Accountability Project, please contact Dipti Singh (Singh@healthlaw.org), Project Director.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. NHeLP advocates, educates and litigates at the federal and state level.

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[3] 42 C.F.R. § 441.20.