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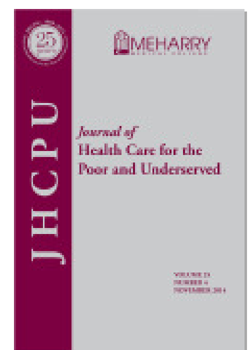

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Does Medicaid Coverage Matter? A Qualitative Multi-State Study of Abortion Affordability for Low-income Women

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Abstract: Medicaid is designed to ensure low-income populations can afford health care. However, not all health services are covered by the program. Most state Medicaid programs restrict abortion coverage, though a small number of state programs offer such coverage. Little is known about how low-income women are affected by differing Medicaid coverage policies regarding abortion. We conducted in-depth interviews with 98 low-income women who had abortions. We found that women's impressions about abortion costs and the availability of Medicaid coverage are generally accurate and that women rely predominantly on abortion facilities for confirmatory cost and coverage information. Additionally, when abortion is out of financial reach, women and the people in their lives experience numerous emotional and financial harms. Policies that aim to ensure abortion is affordable largely prevent these harms, though the availability of Medicaid coverage does not always guarantee access to affordable care. Findings can help advance evidence-based policies.

Key words: Medicaid, abortion, qualitative, women.

Over nine million women of reproductive age (aged 15–44) in the United States are enrolled in Medicaid or the Children's Health Insurance Program (CHIP), income-qualifying government programs designed to provide health insurance for those that could otherwise not afford health care.[1] While such programs are a critical source of health care coverage for many services, they do not provide coverage for all health care needs.

Abortion is often excluded from coverage. Since 1976 the Hyde Amendment has prohibited federal Medicaid funding for abortion except in limited cases. Federal funding is supposed to be available for abortion when a pregnancy results from rape or incest, or endangers a woman's life. States can use their own funds to cover abortion in broader circumstances. Thirty-two states and the District of Columbia follow the federal example and restrict Medicaid coverage of abortion to cases of rape, incest, or life endangerment.[2] However, because of gaps between policy and practice, Medicaid

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coverage of abortion in these states is largely inaccessible, regardless of the circumstances.[3] Only 17 states have policies indicating they provide broad abortion coverage.[2]

Policies that outline what health services are covered by Medicaid affect people insured by the program, who are more likely than the general population to be poor and members of racial or ethnic minority groups.[4] These same populations have higher rates of unintended pregnancy and abortion compared with higher-income or non-Hispanic White women.[5] Data show that most low-income women in the United States pay out of pocket for abortion care and find gathering funds for the time-sensitive procedure to be challenging.[6]

Abortions cost an average of $470 in the first trimester,[7] and the average pregnant woman on Medicaid has an income of approximately $1,750 a month,[8] meaning paying for an abortion would consume over 25% of a low-income woman's monthly income. However, not all low-income women pay for care out-of-pocket. A small portion of women on Medicaid use their insurance for coverage, with most of these women living in the few states where Medicaid provides broad abortion coverage.[3] In 2010, the most recent year in which data are available, state Medicaid programs covered almost 181,000 abortions.[9]

There is a growing body of literature that shows that restricting Medicaid coverage of abortion can delay abortion access while women search for the funds to pay out-of-pocket for care, or can altogether impede abortion access when women are unable to gather the necessary funds.[10–11] We sought to build on this literature and draw comparisons between the knowledge and experiences of women living in states where Medicaid coverage is and is not available for abortion. This work is necessary as understanding the full impact of Medicaid coverage of abortion policies is critical for promoting state and federal policies that respond to the health care needs of low-income women

We focus on answering the following questions: 1) What do women know about the cost of abortion and the availability of Medicaid coverage for abortion? 2) Where do women obtain this information? and 3) What are women's experiences paying for care?

Methods

A qualitative study was selected for this investigation as it provided an opportunity to explore our research questions in-depth and to feature the voices of women themselves.[12] This exploratory step is critical as little is known about women's experiences with differing abortion coverage policies and hearing from the women most affected by these policies helps illuminate their full impact. Data were gathered from two similarly-focused studies which involved in-depth interviews with low-income women who had abortions. Two of the article's authors (AD and RM), collected all of the data for the two studies; both authors have extensive training in qualitative data collections methods.

In the first study, conducted between October 2010 and February 2011, we conducted interviews with low-income women who obtained abortions in four states. We chose to conduct interviews with women who obtained care in Arizona, Florida, Oregon, and New York because prior research shows that in two of these states (Oregon and New York) Medicaid coverage for abortion is readily available, whereas in the other two states (Arizona and Florida) Medicaid coverage for abortion is difficult to secure.[3]

A convenience sample of women was recruited through community-based websites such as Craigslist and Facebook. In order to be eligible for the study, a woman had to report she: 1) was age 18 or older, 2) had an abortion within the past two years, 3) resided in one of the four study states at the time of the abortion, and 4) was low-income, which we defined as meeting the Medicaid income qualifications of the state where she had the abortion (Table 1). As is best practice in qualitative research, we did not define our sample size for each state or for the entire sample *a priori*, but instead stopped collecting data once we obtained predictability and reached a saturation of themes for each state and for the overall sample.[12]

During interviews, a semi-structured in-depth interview guide was used, which allowed for exploring consistent themes across interviewers while also allowing enough flexibility to probe for emergent themes.[12] Major domains of the interview guide included: 1) knowledge of Medicaid policies regarding abortion; 2) attitudes and opinions regarding current abortion laws; and 3) experiences obtaining and paying for abortion. After the interviews, participants were sent a $35 gift card in return for participation.

In the second study, conducted from December 2011 to June 2012, we conducted in-depth interviews with low-income women in Massachusetts. We chose to recruit women in Massachusetts because we viewed it as a state where abortion coverage is likely widely available given that almost all women in Massachusetts are insured[13] and

Table 1.

MEDICAID INDICATORS RELATED TO ABORTION BY STATE AT THE TIME OF INTERVIEW

	Medicaid policy regarding abortion	Poverty level standards for pregnant women to enroll in Medicaid
Arizona	By law, abortion coverage should be available in all or most cases, but in practice is rarely ever covered.	150%
Florida	By law, abortion coverage is only available in cases of rape, incest, and life endangerment of the woman, but in practice is rarely ever covered.	185%
Massachusetts	By law, abortion coverage should be available in all or most cases, and in practice appears to be.	200%
New York	By law, abortion coverage should be available in all or most cases, and in practice appears to be.	200%
Oregon	By law, abortion coverage should be available in all or most cases, and in practice appears to be.	185%

that almost all public or subsidized insurance programs in the state provide abortion coverage.[14] Women were again recruited through community based websites and similar eligibility criteria were used. To participate in the study a woman had to: 1) be age 18 or older, 2) have had an abortion within the past three years, 3) have resided in Massachusetts at the time of the abortion, 4) have been uninsured or on a public or subsidized health insurance plan at the time of abortion, and 5) be low-income, which again was defined as meeting the Medicaid income qualifications of the state (Table 1). As with the prior study, data collection was stopped when we obtained predictability and saturation of themes.

A semi-structured interview guide was also used for this study and the major domains of the interview guide were the participant's experiences: 1) enrolling in and staying on health insurance; 2) obtaining and paying for abortion; 3) obtaining and paying for contraceptives; and 4) knowledge of and attitudes towards laws affecting abortion and contraceptive coverage. Participants were given a $50 gift card in return for participation.

Prior to participating in the interviews, women from both studies provided verbal informed consent. All study procedures were reviewed and approved by Allendale Institutional Review Board (IRB), a private IRB.

To analyze data from both studies, all interviews, which were digitally recorded, were transcribed verbatim. Data were uploaded into Atlas.ti (Scientific Software Development, Berlin, Germany), a qualitative software program. We developed a short list of codes based on our central research questions. The study team coded each transcript using the initial codes and adding new codes as additional themes emerged from the data. After coding each transcript, the study team conferred about proposed new codes and reviewed one another's coded transcripts for consistency in coding. This iteratively generated a standard codebook used across all transcripts and helped build consensus on how each transcript should be coded. Each code was then summarized and discussed in-depth within the study team which allowed for identification of the relationships between the codes and for the most salient themes within and across codes. We then searched for negative evidence of identified themes attempting to disprove our findings and refine our results. Last, after further sharpening of identified themes, we selected quotations which best illustrated study themes.[15] We identify each quotation with a pseudonym, the state in which a participant sought an abortion, and key identifying demographic characteristics (age, race, and ethnicity).

Results

Demographic characteristics and abortion characteristics. Interviewees were fairly evenly distributed across the five study states (Table 2). Participants were on average 31 years of age. Fifty-seven percent of participants identified as White, with the remainder identifying as women of color. Sixty percent of participants had at least one child (data not shown), half were single, and 52% were not working at the time of interview.

Sixty-eight percent of women reported they had only had one abortion, with the remainder reporting two or more abortions (data not shown). Almost 90% of women reported their most recent or only abortion occurred within the first trimester (data not

Table 2.

PARTICIPANT CHARACTERISTICS

	Overall sample	Arizona	Florida	Massachusetts	New York	Oregon
Participants, n (%)	98 (100)	16 (16)	20 (20)	27 (28)	20 (20)	15 (15)
Age, mean (range)	31 (18–55)	30 (19–51)	31 (20–48)	34 (24–46)	29 (20–45)	28 (18–55)
Race and ethnicity, n (%)						
Asian	4 (4)	0 (0)	1 (5)	2 (7)	1 (5)	0 (0)
Black	15 (15)	1 (6)	3 (15)	10 (37)	1 (5)	0 (0)
Black, Hispanic	3 (3)	1 (6)	0 (0)	1 (4)	1 (5)	0 (0)
American Indian or Alaskan Native	3 (3)	1 (6)	0 (0)	1 (4)	1 (5)	0 (0)
White	56 (57)	8 (50)	11 (55)	12 (44)	10 (50)	15 (100)
White, Hispanic	15 (15)	5 (31)	5 (25)	1 (4)	4 (20)	0 (0)
Other	2 (2)	0 (0)	0 (0)	0 (0)	2 (10)	0 (0)
Relationship status, n (%)						
In a relationship	31 (32)	4 (25)	4 (20)	12 (44)	5 (25)	6 (40)
Married	16 (16)	3 (19)	5 (25)	4 (15)	3 (15)	1 (7)
Single	49 (50)	9 (56)	10 (50)	11 (41)	11 (55)	8 (53)
Missing	2 (2)	0 (0)	1 (5)	0 (0)	1 (5)	0 (0)
Current student, n (%)	18 (18)	7 (44)	3 (15)	4 (15)	2 (10)	2 (13)
Work status, n (%)						
Not working	52 (53)	7 (44)	11(55)	17 (63)	9 (45)	8 (53)
Working part-time	33 (34)	8 (50)	5 (25)	6 (22)	9 (45)	5 (33)
Working full-time	11 (11)	1 (6)	4 (20)	2 (7)	2 (10)	2 (13)
Temporarily employed	2 (2)	0 (0)	0 (0)	2 (7)	0 (0)	0 (0)
Number of pregnancies, mean (range)	3.3 (1–24)	4.1 (1–24)	2.6 (1–7)	4.4 (1–11)	2.6 (1–7)	2.1 (1–5)
Number of children	1.2 (0–6)	0.9 (0–3)	1.2 (0–4)	2.1 (0–6)	0.8 (0–4)	0.8 (0–4)
Number of miscarriages	0.5 (0–20)	1.7 (0–20)	0.2 (0–2)	0.4 (0–3)	0.4 (0–1)	0.1 (0–1)
Number of abortions	1.5 (1–5)	1.4 (1–3)	1.3 (1–3)	1.9 (1–5)	1.5 (1–3)	1.1 (1–3)

shown) with the average abortion occurring at eight weeks gestation (Table 3). Overall, 63% reported having insurance at the time of their most recent or only abortion. Among insured women, most had public insurance. Women reported using multiple methods to pay for the procedure. Notable state differences emerged in relation to forms of payment for abortion; when considering Arizona and Florida together only 3% of women used public insurance to cover their procedures, whereas 60% of women did so when combining data from Massachusetts, New York, and Oregon.

Knowledge about abortion costs and coverage. We asked women to recall what they knew about abortion costs and coverage prior to obtaining an abortion. Across study states, regardless of the Medicaid policy regarding abortion coverage, women reported little concrete knowledge about abortion costs and the potential for coverage. However, they did have impressions informed by word-of-mouth discussions with other women in their lives who had abortions, past individual experiences with abortion, and past individual experiences with other health care services. Distinct state-level patterns emerged.

Prior to gathering information about the cost of abortion or potential for insurance coverage, women in Arizona and Florida, where Medicaid coverage is generally not available for abortion, almost universally believed that their insurer would not cover abortion. These views were most strongly informed by prior difficulties accessing insurance coverage for abortion and other reproductive health services, including emergency contraception and testing for sexually transmitted infections/diseases. Sally said,

> Arizona doesn't cover any options for pregnant women. I mean, it doesn't wanna cover the costs of midwives. [. . .] It doesn't wanna cover the cost of birth control. It doesn't wanna cover the cost of abortion. It doesn't wanna cover the cost of a lot of prenatal things [Arizona, age 25, Non-Hispanic, White].

Women in these states also believed that obtaining an abortion is expensive and that the procedure must be paid for out-of-pocket at considerable personal costs. Helen summed this up when she said,

> I know a lot of people that have had an abortion. Most of my friends and a lot of my family members have. I just know that every time I know somebody who has to go through that, it's a struggle having to come up with the money because they're very rarely ever covered by health insurance. So, even my friends that have insurance still have to pay out-of-pocket for their abortions, and you know it's unexpected. I mean, women don't know that they're going to have to have one, we don't plan for that. We don't put away a fund for it or anything. So it's really an unexpected expense, and I know a lot of people that have been really burdened by it [Arizona, age 24, Non-Hispanic, White].

On the other hand, women in Massachusetts, New York, and Oregon, states where Medicaid coverage of abortion is broadly available, commonly expected that abortion would be fully covered by their insurance. Again, women's impressions about the availability of coverage emerged predominantly from past positive experiences using Medicaid for other types of health care. Women in Massachusetts, for example, repeatedly stated

Table 3.

CHARACTERISTICS OF PARTICIPANTS' MOST RECENT ABORTION[a]

	Overall sample (n = 98)	Arizona (n = 16)	Florida (n = 20)	Massachusetts (n = 27)	New York (n = 20)	Oregon (n = 15)
Abortion type, n (%)						
Medical	23 (23)	5 (31)	6 (30)	4 (15)	6 (30)	2 (13)
Surgical	75 (77)	11 (69)	14 (70)	23 (85)	14 (70)	13 (87)
Abortion gestation in weeks, mean (range)	8.3 (1.5–23.5)	8.5 (3–23.5)	8.7 (1.5–16)	8.7 (5.5–14)	7.1 (2–12)	8.5 (4–16.5)
Type of insurance at time of abortion, n (%)						
Public	54 (55)	6 (37)	6 (30)	20 (74)	11 (55)	10 (67)
Private	8 (8)	1 (6)	2 (10)	0 (0)	4 (20)	1 (7)
Uninsured	36 (37)	9 (56)	12 (60)	7 (26)	5 (25)	4 (27)
Method(s) of payment for abortion,[1] n (%)						
Out of pocket	49 (50)	14 (88)	13 (65)	6 (22)	8 (40)	8 (53)
Private insurance	2 (2)	0 (0)	0 (0)	0 (0)	2 (10)	0 (0)
Public insurance	38 (39)	1 (6)	0 (0)	18 (67)	10 (50)	9 (60)
Abortion fund	2 (2)	0 (0)	1 (5)	0 (0)	0 (0)	1 (7)
Family/friend	39 (40)	8 (50)	16 (80)	6 (22)	4 (20)	5 (33)
Clinic discount	10 (10)	4 (25)	3 (15)	0 (0)	2 (10)	1 (7)

[a]Percent may not add up to 100%; multiple methods of payment could be selected.

that they did not question if their Medicaid would cover abortion because it "covers everything" [Ciara, age 46, Non-Hispanic, Black] or, as Tracy stated, "They pay for abortions, they pay for teeth, they pay for everything" [age 36, Non-Hispanic, White].

Obtaining information about abortion costs and coverage. Women's impressions of the cost of abortion and the potential for insurance coverage were supplemented by information gathered from (in order of reliance): abortion facilities, insurance providers, and other health care providers.

Women almost universally recalled that the cost of abortion and the availability of insurance coverage for abortion were explained to them upfront when they first called a facility to make an abortion appointment. Women perceived staff at abortion facilities as being able to provide this information quickly and accurately. Participants also spontaneously noted the importance of being able to access this information confidentially. Because a subset of interviewees did not want insurers or other health care providers to know about their abortion, they elected to rely exclusively on the abortion facilities for information. For example, Malie explained how she found out about the cost of her abortion: "[Clinic name] actually helped me out 'cause it was a secret. I was still able to go to them and they told me my rights and everything and they spoke to me. That's the only place I checked" [Arizona, age 19, White, Hispanic].

There were state-level differences in the information given to women by staff at abortion facilities. Women in Arizona and Florida said they were informed that the state Medicaid program does not cover abortion or that it would be extraordinarily difficult to obtain coverage. For example, Trina was told that Medicaid is "really uncooperative" [Florida, age 21, White, Non-Hispanic]. On the other hand, women in New York, Oregon, and Massachusetts were almost universally informed that coverage was available. Moreover, during these initial phone calls, women in these three states who were uninsured often reported being provided with information about enrolling in Medicaid, an issue that did not emerge in reports from women in Arizona or Florida. Hannah recalled being told about enrollment when she called an abortion facility: "Apparently, if I got all the paperwork together and qualified, then it would; the procedure would be paid for" [Oregon, age 25, White, Non-Hispanic].

The second most common source of information about abortion costs and coverage was insurance providers. Though some women feared being judged for calling to inquire about abortion benefits, no woman reported actually experiencing such judgment. Across study states women described calls to their insurance providers as matter of fact and straightforward requests for information about benefits. However, the state-level outcomes of these calls varied markedly. Women in Massachusetts, Oregon, and New York ended their calls satisfied with the information received whereas women living in states without accessible Medicaid coverage described feelings of devastation when they confirmed their suspicion that coverage was unavailable. Ana explained, "I did call it and they said they didn't cover it. And then, and then, that's it. I was just left alone. Like, I had, I had *no resources*" [Arizona, age 25, White, Hispanic, emphasis in the original].

A sizable minority of women, all in states where Medicaid coverage of abortion is available, reported receiving information from their regular health care providers dur-

ing routine health visits or when confirming the pregnancy and discussing pregnancy options. Overall, these women appeared comfortable talking with their regular health care providers because they were the providers with which they discussed all of their health issues. Megan explained,

> I've been using my doctor for a long time. I went there for another reason and I figured I would get it [the pregnancy] verified while I was there. And he told me if I wanted to do that option [abortion] I could get help with it from insurance. [Oregon, age 23, White, Non-Hispanic].

Paying for care when Medicaid coverage is available. Women's experiences paying for abortion care varied widely and were almost entirely dependent on their home state's policies regarding Medicaid coverage. Insured women residing in Massachusetts, New York, and Oregon largely described a straightforward and "pretty easy" payment process. Participants reported that they either filled out a small amount of paperwork or simply showed their Medicaid identification card to abortion clinic staff and their payment was completed. Ciara explained: "Well, all I had to do was just show my card and they ran everything through the computer so it wasn't really no aggravation or anything." [Massachusetts, age 46, Black, Non-Hispanic].

Some women in these three states who were eligible for Medicaid, but uninsured at the time of their pregnancy, were able to quickly enroll in Medicaid in order to obtain coverage for their abortion. For uninsured women in New York, the enrollment process was facilitated by presumptive eligibility, a process where women can be considered presumptively eligible for Medicaid and quickly and temporarily enrolled in the program to cover the cost of an abortion.[16] Women in New York spontaneously expressed that presumptive eligibility had a number of benefits, namely making the enrollment process easy and ensuring no unnecessary delays between when they confirmed their pregnancy and had an abortion. Lavona said that she obtained pregnancy confirmation and options counseling, enrolled in Medicaid, and obtained an abortion "all in one day." [New York, age 29, Black, Hispanic]. Later in the interview she further said, "I just signed a paper for them to process it through Medicaid and that was it. I never heard of a bill. Never saw a bill."

Most women in these three states who enrolled or were able to enroll in insurance at the time of their abortion reported that they would not have had the resources to pay for their care otherwise. Ali explained, "I really needed it [coverage]. I didn't have $500 to spend on this. And I definitely didn't have thousands in order to raise a child" [Oregon, age 28, White, Non-Hispanic]. Similarly, Lilah related: "I didn't have $600 at the time, so I would've had to figure out a way to put it on a credit card or borrow it or something. I was really relieved when I found out that my Medicaid would cover it" [New York, age 21, White, Non-Hispanic].

Although women in these three states largely had positive things to say about using Medicaid for abortion care, a minority of women reported challenges enrolling in Medicaid in time for the procedure, a challenge that led to delays obtaining care while waiting for insurance to become active or finding alternative resources to pay for care. Meg stated,

> I did think about that [waiting until insurance came through] but I realized it was more important for me to do what I needed to do. I remember my partner was like, "Can we just wait? Can you just wait?" He didn't like the idea of spending so much money on it, but I said, "You know what? No. I really need to just do this. I need to really take care of it." So that was kind of a struggle but I just decided the most important thing was just make the appointment and just get it done. [Massachusetts, age 29, White, Non-Hispanic].

Additionally, for a sizable minority of insured women, concerns about leaving a "paper trail" led to women not using their insurance and paying out-of-pocket. For some of these women the concern was an abstract fear about anyone finding out about the abortion. Rita explained, "They asked me if I had insurance. I just said 'No.' I just didn't want that to be on my insurance 'cause I didn't know if that was private information or not. I don't know who had access to it, so just to be kinda safer than sorry" [Massachusetts, age 33, Black, Non-Hispanic]. For a smaller group of young women, the concern was about a parent finding out, since they were on a parent's insurance plan. Emily reported, "I didn't want my dad to find out so that [using insurance] wasn't even really an option for me" [New York, age 20, Black, Non-Hispanic].

Paying for care when Medicaid coverage is unavailable. Women living in Arizona and Florida, states where Medicaid coverage is largely not available, and women who were unable to access Medicaid coverage in Massachusetts, Oregon, or New York turned to a number of different resources to pay for care, including drawing from their own resources and borrowing money.

While a small number of women had savings that they could tap into, most women had to wait for their paychecks, work additional hours, juggle bills, cut back on personal and household necessities (usually food), take out loans, use credit cards, and/or sell personal possessions to gather the necessary funds for their abortion. Most often, women pulled from multiple resources, as described by Destiny:

> I did a payday loan against my [pay] check. Some bills did not get paid. [. . .]. I didn't send my daughter to preschool. [. . .] Whatever money I had to pay for other stuff, I was trying to save and hustle it. I actually pawned some of my jewelry as well. [Florida, age 27, Black, Non-Hispanic].

While women did their best to stretch their resources, some participants said they simply did not make enough money to make ends meet. For example, Trina explained how she found herself without electricity for 13 days, a situation which not only affected her but also her family:

> I saved as much money as I could with still paying my rent and water and electric and car payment and child support and everything else that I have to pay. I ended up being late on my electric bill. [. . .] You can't have groceries when you don't have electricity. [. . .] Hot water heaters are electric. Little things like that that you take for granted until you don't have electricity, [you have] ice cold showers and no groceries in the fridge [Florida, age 21, White, Non-Hispanic].

Women reported that pulling from their limited resources only served to make the time leading up to having an abortion more emotionally difficult. Participants almost universally called the process of scrimping and saving for an abortion "stressful," "hard," "humiliating," and "frustrating."

Many women reported that saving for the abortion not only affected them before the procedure, but also after the procedure. Women described paying back loans, unpaid bills, and/or credit card debts for months after their abortion. For example, Carmen in Arizona took out a title loan on her car to pay for her abortion, which took her an estimated five months to pay back [age 26, White, Hispanic].

When their own resources were insufficient, women sought financial assistance from someone in their lives. Women related that because they lived in low-income families and communities, it was not easy for the gather this support. Vanessa received help from her mother and explained the emotional and financial impact on the family:

> She just worked as much as she could for like a week. [. . .] That was basically all her money and she was completely broke after that and it was hard for her to get by. [. . .] It didn't just affect me, it affected her, and I have a little brother that we're living with too. [. . .] They felt the impact of not having as many groceries and the necessities that went with that [Oregon, age 18, White, Non-Hispanic].

A smaller portion of women received reductions in fees at the abortion clinic. Some women said they automatically qualified for the discount by having a Medicaid card; others said they had to provide the clinic with information about their financial circumstances. Women described the process as straightforward and easy to navigate. Monica related:

> You just give them the paperwork that they asked for. And then they have a sheet they fill out and afterwards they tell you, "Ok your discount is this much. You qualify for this much discount. So you have to pay this much [Arizona, age 24, White, Hispanic]."

Least commonly, women reported obtaining financial support from abortion funds, non-profit organizations that help women pay for abortion care. Because only two women had experiences with abortion funds, it is difficult to determine a pattern of women's experiences with the funds.

Discussion

Our findings suggest that policies regarding Medicaid coverage of abortion affect the lives of women and their families in numerous ways. Restrictive coverage policies appear to force women to take measures to raise money for an abortion that may put their health and wellbeing at risk, promote short and longer-term financial instability, and increase the difficulty of implementing an abortion decision, thereby interfering with women's reproductive life plans. Restrictive Medicaid coverage policies also appear to have ripple effects on children, partners, and parents of women seeking abortion services.

Full coverage of abortion in the Medicaid program eliminates most of the above

challenges. When coverage is available, there is little to no need for women or others in their lives to make financial sacrifices, and there is rarely a scramble for money that provokes feelings of indignity or delays abortion care. However, gaps in access to affordable abortion care were present in states where Medicaid coverage was available. Women unable to enroll in Medicaid in a timely manner were forced to pay out-of-pocket for care. Presumptive eligibility for Medicaid for pregnant women helped resolve this access barrier. Additionally, some women did not use their Medicaid due to privacy concerns. State-level insurance statutes and regulations could help mediate the barrier to confidential care.[17]

Other important themes emerged from states where coverage of abortion was available. First, women reported that staff at abortion facilities directed them to enroll in Medicaid. This suggests that these staff and facilities are an underutilized resource for helping pregnant women enroll in public or subsidized insurance programs. Staff members' roles as facilitators in the enrollment process may become even more critical under the Affordable Care Act (ACA), when millions of women of reproductive age become eligible for insurance.[18] This finding has practice implications for abortion facilities as under the ACA it will be paramount that front-line staff be well educated about new insurance coverage policies regarding abortion. We speculate that providing this information may be challenging under the ACA as more women are insured and more insurers emerge in the marketplace. This speculation is supported by research conducted in Massachusetts where after state-level reform health care providers reported limited knowledge about the specifics of abortion coverage in the then new health care landscape.[19]

Next, women in Massachusetts, New York, and Oregon reported comfort talking with their primary health care providers about their abortion care needs. This suggests that in states where Medicaid coverage of abortion is available discussions about abortion are not isolated to the abortion provision setting. It also suggests that there are a range of health care providers in these states providing pregnancy options counseling, offering information about costs and coverage, and directing women to abortion clinics. The referrals seen in this study in Medicaid coverage states—where staff at abortion facilities refer women to Medicaid and where primary care providers refer women to abortion providers—indicate a health system responding to women's comprehensive health needs.

Our results are consistent with prior research illuminating the harmful effects on women when Medicaid coverage of abortion is restricted.[10–11] There is no identifiable research highlighting the benefits of providing Medicaid coverage of abortion to women, though prior research has shown that the existence of state-level Medicaid coverage of abortion does not always lead to access to coverage because of delays enrolling in Medicaid.[14]

We believe that a nationally representative study is needed to test our emergent hypothesis that low-income abortion clients in states without Medicaid coverage of abortion experience significantly more emotional and financial harm than clients in states where coverage is available. More research is needed to quantify the extent of emotional and financial duress placed on women and their families, and how this

duress affects individuals and families over time. Additionally, more work is needed to determine if our findings about the benefits of available abortion coverage hold true across the few states where this coverage is available and if there are other unidentified benefits. This work will be of particular importance under the ACA. Some data suggest that women will have access to abortion coverage in the few states where Medicaid coverage is available in all cases and states are electing to expand Medicaid coverage.[9] However, because of the large number of women enrolling in Medicaid and the number of states enacting severe abortion coverage restrictions under the ACA, it likely that more women than ever will be subject to restrictions on abortion coverage.[20]

Limitations and strengths. Qualitative methods are powerful for collecting rich, hypothesis-generating data.[12] However, our findings may not be generalizable to the population of low-income women who obtain abortions. Additionally, it is not known how women in our convenience sample differ from those who did not participate in the study. Another limitation is that this study relies on self-report and some details may suffer from recall bias. However, we recruited women who reported having obtained abortions in the recent past and viewed cautiously details women reported difficulty remembering.

Despite these limitations, our study provides new and insightful information about the effects of differing state Medicaid coverage of abortion policies, data that emerge from the individuals most affected by these policies. Additionally, data were gathered from states in which Medicaid coverage of abortion appears to be either widely or not at all accessible, providing a critical opportunity for drawing rich comparisons. Notably, interviews were conducted with a racially and ethnically diverse sample of low-income women. This is a notable strength to this paper as Black and Hispanic women have higher rates of abortion than non-Hispanic White women, just as low-income women have higher rates of abortion when compared with women with higher incomes.[5]

Conclusion. To the extent that federal and state abortion policies are informed by evidence, it is critical to consider the intended and unintended effects of differing Medicaid coverage policies regarding abortion. Restrictions on Medicaid coverage of abortion are common and have important effects, many deleterious for women and their families. State Medicaid coverage of abortion ameliorates many of the harms of coverage restrictions and should be a central component of any efforts to ensure abortion policies are responsive to the health care needs of women and their families.

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