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At What Cost? Payment for Abortion Care by U.S. Women

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ABSTRACT

Background: Most U.S. abortion patients are poor or low-income, yet most pay several hundred dollars out of pocket for these services. This study explores how women procure these funds.
Methods: iPad-administered surveys were implemented among 639 women obtaining abortions at six geographically diverse healthcare facilities. Women provided information about insurance coverage, payment for service, acquisition of funds, and ancillary costs incurred.
Findings: Only 36% of the sample lacked health insurance, but at least 69% were paying out of pocket for abortion care. Women were twice as likely to pay using Medicaid (16% of abortions) than private health insurance (7%). The most common reason women were not using private insurance was because it did not cover the procedure (46%), or they were unsure if it was covered (29%). Among women who did not use insurance for their abortion, 52% found it difficult to pay for the procedure. One half of patients relied on someone else to help cover costs, most commonly the man involved in the pregnancy. Most women incurred ancillary expenses in the form of transportation (mean, $44), and a minority also reported lost wages (mean, $198), childcare expenses (mean, $57) and other travel-related costs (mean, $140). Substantial minorities also delayed or did not pay bills such as rent (14%), food (16%), or utilities and other bills (30%) to pay for the abortion.
Conclusions: Public and private health insurance plan coverage of abortion care services could ease the financial strain experienced by abortion patients, many of whom are low income.
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Introduction

It is often assumed that individuals with health insurance can use it to pay for basic health care services. That is not the case with abortion care. Although 61% of abortion patients in 2008 had some type of health insurance coverage, 57% paid out of pocket for the procedure (Jones et al., 2010). Little is known about the reasons for this pattern.

The Hyde Amendment, first enacted in 1976, stipulates that federal Medicaid dollars cannot be used to pay for abortions except in cases where the pregnancy results from rape or incest, or endangers the woman's life. Seventeen states use their own funds to pay for abortion care for residents with Medicaid coverage, including several large states such as California, New York, and New Jersey. In turn, 20% of abortions in the United States were paid for by Medicaid in 2008 (Jones et al., 2010). Still, most women with Medicaid coverage would have to pay for abortions out of pocket. Moreover, even in the 17 states where Medicaid does cover abortion services, there are numerous barriers. For example, Illinois and Arizona are under court order to cover medically necessary abortions, but in practice almost no Medicaid abortions are funded in these states (Sonfield, Alrich, & Gold, 2008). In the remaining 15 states, barriers such as low reimbursement rates and delays in enrollment prevent some women and providers from using Medicaid for abortion services (Bessett et al., 2011; Dennis & Blanchard, 2013).

Only 12% of all U.S. abortions in 2008 were paid for by private health insurance and almost two thirds of abortion patients with this type of coverage did not use it (Jones et al., 2010). Two smaller studies found that the most common reason for this pattern is that women did not know if their plan covered abortion care services (Cockrill & Weitz, 2010; Van Bebber et al., 2006). This could be because many employers, including the federal and many state governments, as well as some religious and private employers, purposely exclude abortion coverage from their plans (Guttmacher Institute, 2013). Less commonly, concerns about confidentiality are another reason women forego

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paying with private health insurance (Cockrill & Weitz, 2010; Van Bebber et al., 2006).

In 2009, the average cost of first-trimester abortion was $470 (Jones & Kooistra, 2011), and most women obtaining abortions were poor or low income (Jones et al., 2010). These patterns suggest that abortion patients are confronted with substantial financial burdens to pay for these procedures. In 2008, 13% of abortion patients relied on financial assistance—in the form of discounts provided by the clinic or abortion fund subsidies—to pay for some or all of the cost of the abortion. Abortion funds are nonprofit organizations that collect private donations and work with abortion providers to help cover the cost of the procedure for women who otherwise could not afford it (Towey, Poggi, & Roth, 2005). That abortion patients are as likely to rely on financial assistance as on private insurance to pay for a termination suggests that these funds play an important role in financing abortion services.

How women pay for abortions may also influence at what stage in the pregnancy they are able to do so. Women seeking second trimester terminations face even greater financial obstacles as these procedures can cost two and three times more than those in the first trimester (Henshaw & Finer, 2003). Moreover, these patients cite travel and procedure costs among the most common reasons for delays in seeking care (Drey et al., 2006; Finer et al., 2006; Foster et al., 2008). Research has demonstrated that second-trimester abortion patients are more likely to use health insurance—both private and Medicaid—to pay for the procedure than first-trimester patients (Jones & Finer, 2012), suggesting that women able to use their health insurance to pay for the procedure are more likely to be able to afford the more expensive services.

The amount charged for abortion does not include indirect costs in the form of lost wages, childcare, and transportation. One study of 212 medical abortion patients found that women incurred indirect costs of $45 in addition to what they paid for the early abortion (Van Bebber et al., 2006). However, the sample was more educated than the larger population of abortion patients, obtaining their abortions before 9 weeks of pregnancy, and predominantly White; it is unclear whether lower income women would incur higher or lower ancillary costs. Some second trimester abortions require sequential visits to the facility over a 2- or 3-day period, and seven states require that women both receive their counseling 24 to 72 hours before the abortion and do so in person, necessitating multiple visits to the facility. These conditions can also increase the ancillary costs of abortion care.

Using data from women obtaining abortions across the United States, this study helps to fill in the gaps about how women pay for these services. Our analysis provides insights into why women with private health insurance do not use it to pay for abortion services and the role of financial assistance in subsidizing these costs. We also examine the ancillary expenses that many abortion patients incur (in the form of transportation, lost wages, etc.) and how women feel about requesting financial support.

Materials and Methods

Procedures

Data for this analysis were collected as part of a larger study of abortion care patients conducted between May and July 2011 at six abortion providers across the United States. We used purposive sampling, selecting facilities specifically based on their characteristics, in particular, their geographical diversity and wide range in gestational ages at which they provide abortion care. The facilities were located in major cities in Arkansas, California, Georgia, Illinois, New Jersey, and Texas. Recruitment was conducted over 3 to 7 consecutive days at each facility, and most abortion care patients served during the day were invited to participate. Respondents were recruited in facility waiting rooms and eligible for inclusion in the study if they were a patient at the clinic seeking an abortion or an abortion follow-up appointment, aged 15 or older, and able to speak English or Spanish.

Women completed surveys via a self-administered iPad-based questionnaire in English or Spanish. A research assistant led women through information about the study, provided a short training on the iPad, and participants gave consent before initiating the survey. No identifying information was collected. The survey was created using the iFormBuilder application and the data were transferred to SPSS 18.0 (SPSS Inc, Chicago, IL) for analysis. Participants received $20 remuneration. The study protocol was approved by the Institutional Review Board of the University of California, San Francisco. A total of 757 women were invited to participate, and surveys were collected from 651 women. Twelve women were excluded from the analysis because they ultimately did not obtain abortions.

Measures

Data for this analysis come from one module of a larger survey; other modules covered issues such as birth control history and intentions, experiences with family planning services, relationship dynamics with current sex partners, and other topics. The module used for this analysis included questions on the amount paid for the abortion; where and how those funds were obtained; the relative ease or difficulty paying for the abortion; out-of-pocket expenses related to transportation, lodging, childcare, and lost wages; and women's emotions related to obtaining the financial resources to pay for abortion care.

Measurement of type of health insurance coverage was based on a series of items. Respondents were first asked if they had Medicaid, and names of state-specific programs (e.g., Medi-Cal) were listed. All respondents were then asked if they had non-Medicaid health insurance. Given the complexity of health care plans, it is perhaps not surprising that a small number of respondents ($n = 31$) provided inconsistent responses, indicating that they were covered by both Medicaid and private plans. In these instances, we gave priority to the Medicaid response since it was listed by program name and presumably recognized by respondents.

After type of insurance was assessed, respondents were asked if they were using it to pay for part or all of the cost of the procedure. Thirty-three women with Medicaid coverage residing in two states where abortion services were not covered by state funds reported that they were using Medicaid to pay for some or all of the cost of the abortion; all but 3 of the 33 women reported they were paying some money out of pocket, typically several hundred dollars. The two facilities located in these states offered the service at a discounted fee to women with Medicaid coverage, and patients were informed of this practice. However, perhaps because the logistics of payment were unclear to patients, we assume women thought Medicaid was covering the discount. We recoded these 30 cases to indicate that their insurance was not paying for the procedure (and that they were obtaining a discount). The three cases where women reported

using Medicaid and paying no money out of pocket may have actually been covered for reasons such as rape, incest, or life endangerment and were recorded as being covered by Medicaid.

Analyses

Most women failed to answer at least a few items, but because this is a descriptive study, we utilize all available information on a per item basis and did not rely on listwise deletion. We first compare the sociodemographic profile of the sample to a nationally representative sample of abortion patients (Jones et al., 2010). We then describe the use of insurance for payment of the abortion services and reasons for not using it. We estimate the amounts patients paid to facilities for abortion services by gestational age and how the women obtained the funds used to pay those costs. Because no hypotheses were tested in this descriptive study, we did not assess for differences between any groups.

Results

Most abortion care patients served on recruitment days were invited to participate in the study. The total participation rate was 86.1% for all clinics and ranged from 80.3% to 93.0%.

Demographic Profile

The demographic profile of the sample resembled that of abortion patients nationally on several characteristics, including age, education, and parity (Table 1). The study sample varied from all abortion patients insofar as it contained more poor women, more Black women, and a higher proportion were obtaining second-trimester abortions. In particular, 54% of the sample had an income below the federal poverty level compared with 42% of abortion patients nationally; 21% of the sample was obtaining second-trimester abortions compared with 10%; and, in particular, the sample had a larger proportion of women obtaining abortions at 16 weeks or later (14% compared with 4%). All six sites from which the data were collected offered later second-trimester abortion services, which accounts for the overrepresentation of this group.

Type of insurance coverage among the sample was also similar to abortion patients nationally. About one third of the sample had Medicaid, with 8% of the entire sample (and 22% of all Medicaid recipients) receiving coverage specifically because they were pregnant. A similar proportion—31%—had private health insurance and 36% were uninsured. Fourteen percent of all women, and 40% of those with private insurance, obtained coverage through a parent or spouse (data not shown).

Insurance and Payment for Abortion Services

The majority of those with health insurance did not or could not use it to pay for the procedure; 23% did, including 16% using Medicaid and 7% using private health insurance (Table 2).

A non-negligible minority of women with health insurance, 9%, were unsure whether they were going to use it to pay for the procedure. Two-thirds of these women ($n = 35$) reported having Medicaid for health care coverage, and the majority of those ($n = 22$) resided in a state where it cannot be used to pay for the procedure (data not shown); thus, most would likely be paying out of pocket. It is possible that the women with private health insurance ($n = 18$) would have to file the claim on their own and were unsure if they would do so or if they would be reimbursed.

Regardless of insurance type, the most common reason women were not using their health insurance to pay for the procedure was because it was not covered by their plan (46%; Table 3). A follow-up question revealed that many of these women had been told by the facility or by the insurance company that abortion was not covered, but 36% indicated they just assumed it was not (not shown). Somewhat related, the second most common reason for not using insurance was lack of knowledge as to whether the procedure was covered by the plan (29%). Slightly more than 1 in 10 abortion patients indicated that they did not want to use their insurance or that the facility did not accept their insurance. Patterns in reasons for nonuse were similar by type of health insurance coverage, although among women with private insurance a higher proportion of those who obtained it through a spouse or family member indicated not wanting others to know as a reason for not using insurance compared with those who obtained coverage from another source (18% vs. 10%; data not shown).

Costs of Abortion

On average, women paid the clinic $382 for their abortion, although this includes 21% of abortion patients who indicated they had no out-of-pocket costs (not shown). Almost three quarters of women who had no out-of-pocket costs were using their health insurance, and Medicaid in particular, and the remaining obtained money from other sources, which we discuss below. When women who had no out-of-pocket costs are excluded, the average amount paid was $485, and a few women in the sample paid $3,500 or more. As expected, women obtaining second-trimester abortions paid substantially more for the procedure, $854 on average ($652 when those paying $0 are included) compared with $397 ($319, respectively) for first-trimester patients.

Forty-one percent of all abortion patients in the sample indicated it was somewhat or very difficult to pay for the procedure, and this figure was higher (52%) among women not using health insurance (data not shown). Half of all patients obtained money from other individuals or organizations (Table 4). A majority of women who were not using insurance and who were paying fully out of pocket indicated they obtained money from others (59%), but a substantial minority of those using health insurance did so as well (29%). Among those who received assistance, women most commonly reported that the man involved in the pregnancy helped to pay for the abortion (60%). Patients in the sample were equally likely to indicate that they received a facility discount, relied on an abortion fund, or obtained financial assistance from a family member (20%). Amounts obtained from these sources were often quite substantial, ranging between $300 and $400. (The amounts that individual women obtained from each source were more variable, ranging from $15 to $3,500.) Reliance on all sources was typically higher among women paying the full cost out of pocket than those relying on insurance and, additionally, a higher proportion of women paying all the costs out of pocket obtained money from multiple sources (data not shown).

Regardless of whether the assistance came from an abortion fund, a male partner, or a family member, women's most common characterization of having to obtain money from others was to feel grateful, reported by 86% of those who used abortion funds to 48% of those who obtained money from a male partner

Table 1
Characteristics of Sample Compared with Abortion Patients Nationally

	Study Sample	National Sample
Age group, yrs ($n = 639$)		
<20	17.4	17.6
20–24	34.3	33.4
25–29	23.9	24.4
30–34	14.4	13.5
35–39	7.2	8.2
≥40	2.8	2.9
Union status ($n = 634$)		
Married	12.3	14.8
Cohabiting, not married	21.3	29.2
Not currently married	66.4	56.0
Race and ethnicity ($n = 639$)		
Non-Hispanic White	25.2	36.1
Non-Hispanic Black	48.8	29.6
Non-Hispanic other	7.5	9.4
Hispanic	16.7	24.9
Missing/NA	1.7	–
Education ($n = 638$)		
Less than high school	14.4	18.3
High school graduate/GED	31.8	29.5
Some college/associate degree	37.8	35.8
College graduate or higher	16.0	16.5
Prior births ($n = 637$)		
0	40.2	39.1
1	27.5	26.5
≥2	32.3	34.5
Prior abortions ($n = 635$)		
0	45.9	50.4
1	30.0	28.4
≥2	24.1	21.2
Poverty status ($n = 621$)		
<100%	53.9	42.4
100%–199%	27.5	26.5
≥200%	18.5	31.1
Weeks since last menstrual period ($n = 605$)		
≤12	78.5	89.7
13–15	7.9	6.2
≥16	13.6	4.0
Health insurance coverage ($n = 618$)		
Medicaid	33.8	31.0
"Presumptive" coverage	7.7	NA
Private or other	30.6	35.0
None	35.6	33.0

Abbreviations: GED, graduate equivalency diploma.
Note: National data are from Jones, Finer, and Singh (2010).

(data not shown). Substantial minorities of women who obtained money from abortion funds and family members also characterized the experience as "lifesaving," although few women who obtained money from men indicated this response. A few women reported negative emotions such as "resentful," "humiliating," or "angry" for each of these three sources.

The financial costs of accessing abortion services extended beyond paying for the procedure. Two thirds of patients reported that they incurred additional expenses for transportation, averaging $44 (data not shown). More than one quarter reported $198 in lost wages, and approximately 1 in 10 had to pay an average of $57 for childcare. A small but non-negligible proportion (6%) spent $140 on hotel and related travel costs. To cover these expenses, many women—one third of the sample—had to delay or forego paying bills (e.g., electricity, insurance, car payments [30%]), food (16%), and rent (14%).

Table 2
Distribution of Women Using Insurance to Pay for Abortion Care

	n	%
Yes	141	22.9
Medicaid	*96*	*15.6*
Non-Medicaid	*45*	*7.3*
Don't know	53	8.6
No	423	68.6
Total *n*	617	100.0

Payment for Second-Trimester Abortions

Although women obtaining second-trimester abortions were typically paying twice as much as first-trimester patients, we found few differences between the two with regard to reliance on insurance, levels of reliance on most types of financial assistance, and additional costs. For example, 25% of second-trimester patients were using health insurance to pay for the procedure, compared with 23% of first-trimester patients, and about half in each group obtained money to help pay for some or all of the cost (Table 5). The one notable difference was that more than twice as many second-trimester patients relied on an abortion fund for money compared with first-trimester patients (19% and 8%, respectively). The amount of money obtained from all sources was usually twice as high for second-trimester patients compared with those in the first trimester (not shown). Finally, additional costs incurred by the two groups only seemed to differ in one area: A greater proportion of second-trimester patients reported travel costs compared with first-trimester patients (15% vs. 4%).

Discussion

This study confirms several patterns found in prior research and provides new insights into how women pay for abortion care. In line with abortion patients nationally (Jones et al., 2010), we found that the majority of women in our sample had some type of health insurance, but most still paid out of pocket for this service. Similarly, although women in the sample were about equally likely to have private insurance as to have Medicaid, they were more likely to use the latter to pay for the procedure; more than two thirds of women able to use their insurance to pay for the procedure relied on Medicaid to do so. Given that most women obtaining abortions are poor or low income, Medicaid may substantively increase access to abortion in those states where it is covered. The converse implication is that some women with Medicaid in states that do not cover abortion are unable to access abortion services because of financial barriers.

Also similar to abortion patients nationally (Jones et al., 2010), we found that most women with private health insurance paid for abortion services out of pocket. A small proportion reported doing so because they did not want to use their insurance, with women who obtained coverage through spouses or parents more likely to do so, presumably because it increased the chance that others would find out about the procedure. Our findings suggest that the most common reason women did not use their private insurance is because the procedure was not covered by their plan, and the second most common reason was because women were unsure whether it was covered. It is possible that this second pattern is an indirect indictor of stigma insofar as it suggests that some women do not consider abortion to be a legitimate health care service and do not check to see if it is covered by their plan (Norris et al., 2011). Alternately, because of concerns about confidentiality, women may decide that even if

Table 3
Percentage Distribution of Reasons Women with Insurance Were Not Using It to Pay for Abortion Care

	Total	Medicaid	Non-Medicaid
Insurance doesn't pay for abortion	46.2	41.3	48.4
Not sure if my insurance covers abortion	29.0	37.0	26.2
I don't want to use my insurance	11.8	8.7	13.1
Clinic doesn't accept	10.1	8.7	10.7
Someone else is paying	2.4	2.2	2.5
Total *n*	168	46	122

the procedure were covered, they would not use their insurance and, hence, are not motivated to find out.

Until now, relatively little was known about the extent to which women rely on others to help pay for abortion services. We found that half of patients, and particularly those who pay out of pocket, rely on others for financial assistance—typically several hundred dollars. Perhaps not surprisingly, male partners were the most common source of financial support, and the fact that women were less positive or grateful for this money relative to other sources may be an indicator that it was viewed as a shared burden or responsibility. We also found that many women delayed or did not pay bills to cover the cost of the procedure. Borrowing money and delaying paying bills were even used by a minority of women who were using their health insurance. For poor and low-income women, even meeting a relatively low deductible may be prohibitive. Alternately, these women may have high deductibles or plans that only partially covered the cost of the procedure.

A majority of abortion patients also incur ancillary expenses in the form of transportation, lost wages, and childcare. Although these expenses were lower than those of the procedure itself, they should not be dismissed. Because many women obtaining abortions have limited financial resources, even an unexpected cost of $44 (the average amount two thirds reported paying for transportation) can pose a burden. For women pulling together money to pay for the procedure as well as transportation and missed work, these relatively small amounts can prove impossible to procure and could prevent women from obtaining a wanted abortion.

That most women pay several hundred dollars out of pocket for abortion services (and ancillary costs)—with many relying on other people or organizations to help cover these costs, and with a minority delaying or not paying bills—suggests that abortion is not a decision women take lightly. Rather, it confirms that women's abortion decisions are consequential to their economic well-being both in choosing to terminate a pregnancy (Finer, Frohwirth, Dauphinee, Singh, & Moore, 2005) and in obtaining an abortion.

Table 4
Percentage Distributions of Abortion Patients Who Obtained Financial Assistance Paying for Abortion and Source of Assistance, by Use of Insurance

	Total	Used Insurance for Abortion		
		Yes	No	Don't Know
Did anyone help you pay for abortion				
Yes	50.2	29.1	58.6	40.4
No	45.4	63.8	38.8	48.1
Don't know	4.4	7.1	2.6	11.5
Total *n*	613	141	420	52
Who helped pay (among those who received any assistance)				
Man involved in the pregnancy	60.1	38.8	64.8	54.5
Discount/reduced price	19.7	6.1	23.6	4.5
Abortion fund	19.6	4.1	22.8	18.2
Family member	20.2	12.2	21.2	27.3
Friend	6.9	0	8.2	4.5
Total *n*	330	49	259	22

Table 5
Insurance and Payment Profiles for First and Second Trimester Abortion Patients

	≤12	≥13	Total
	%	%	
Type of health insurance			
Medicaid	32.3	36.0	33.1
Non-Medicaid	33.5	23.2	31.4
Uninsured	34.2	40.8	35.6
Insurance paying for abortion			
Yes	22.6	25.0	23.1
No	69.2	67.7	68.9
Don't know	8.2	7.3	8.0
Help paying for abortion			
Yes	49.7	52.4	50.3
No	46.4	43.5	45.8
Don't know	3.9	4.0	3.9
Sources of financial assistance			
Man involved in the pregnancy	32.0	30.6	31.7
Reduced fee	9.9	11.3	10.2
Abortion fund	8.0	18.5	10.2
Family member	9.7	14.5	10.7
Friend	3.5	2.4	3.2
Additional costs			
Transportation	67.1	74.8	68.7
Work costs	27.2	30.1	27.8
Travel	3.7	15.4	6.2
Childcare	11.0	16.3	12.2
Total *n*	465	125	590

Although prior research has found that second-trimester patients were more likely to use health insurance to pay for the procedure (Jones & Finer, 2012), the current study found no such difference. Our sample had a relatively high proportion of women obtaining second-trimester procedures, and it is possible that this population was less accurately represented in the sample.

We are aware of several limitations of the study. The sample is not representative of all U.S. abortion patients and, in particular, women obtaining second-trimester abortions, Black women, and poor women were overrepresented. In turn, some of our findings might be "distorted"; for example, among the larger population of abortion patients a lower proportion might obtain money from friends, partners, or family members because they are better off financially and obtaining lower cost, first-trimester procedures. The study did not capture women with unwanted pregnancies who were unable to access abortion services, for example because they could not raise the money to pay for the procedure or the associated ancillary expenses. Insurance and payment for medical services are difficult to measure, as indicated by the substantial minority of women who replied "don't know" on questions about insurance coverage and payment for abortion services. In turn, the measures that are the focus of our analysis may contain more error or variance than items such as age and education.

Implications for Practice and Policy

In 2008, there were 1.21 million abortions, and it is estimated that 30% of U.S. women will have an abortion by age 45 (Jones & Kavanaugh, 2011). Despite the frequency of abortion and that

many women will access services at least once in their lives, abortion care remains marginalized within the larger U.S. health care system (Harris, Cooper, Rasinski, Curlin, & Lyerly, 2011; Harris, Debbink, Martin, & Hassinger, 2011b; Joffe, 1995; O'Donnell, Weitz, & Freedman, 2011). Indeed, there are very few, if any, other medically safe and routine services that are uniformly and purposely excluded from health insurance coverage plans. The problem is not likely to be alleviated, and may be exacerbated, under the Affordable Care Act. As of February 2013, eight states had laws in effect restricting insurance coverage of abortion in all private insurance plans written in the state, and 20 restrict abortion coverage in plans that will be offered through the insurance exchanges that will be implemented under the Affordable Care Act (Guttmacher Institute, 2013). Given that abortion patients are disproportionately poor and many pay for their procedures out of pocket, greater efforts are needed to reduce the financial burdens and increase access to abortion care. Expanding coverage of abortion care services by private health insurance plans could ease the financial strain. Expanding public insurance coverage would direct public funds to the most economically vulnerable. Several European countries, including France and England, cover abortions for all women, viewing unintended pregnancy as a public health problem (France 24, 2012).

The repeal of the Hyde Amendment would increase access to abortion for many low-income women. For several decades, a number of grassroots and national organizations have advocated for the repeal of Hyde, and health care reform has brought more attention to these advocacy efforts. Unfortunately, even legislative bodies composed of predominantly abortion rights supporters have failed, or not even seriously attempted, to stop Hyde's annual approval. The findings of this study suggest that rather than assuming responsibility for the public's health, governments—both state and federal—have privatized the costs of exercising the constitutional right to abortion to women, their communities, and the private donors who support abortion funds.

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References

Bessett, D., Gorski, K., Jinadasa, D., Ostrow, M., & Peterson, M. (2011). Out of time and out of pocket: Experiences of women seeking state-subsidized insurance for abortion care in Massachusetts. *Women's Health Issues*. 21–3S, S21–S25.

Cockrill, K., & Weitz, T. A. (2010). Abortion patients' perceptions of abortion regulation. *Womens Health Issues*, 20, 12–19.

Dennis, A., & Blanchard, K. (2013). Abortion providers' experiences with Medicaid abortion coverage policies: A qualitative multistate study. *Health Services Research*, 48, 236–252.

Drey, E. A., Foster, D. G., Jackson, R. A., Lee, S. J., Cardenas, L. H., & Darney, P. D. (2006). Risk factors associated with presenting for abortion in the second trimester. *Obstetrics and Gynecology*, 107, 128–135.

Finer, L. B., Frohwirth, L. F., Dauphinee, L. A., Singh, S., & Moore, A. M. (2005). Reasons U.S. women have abortions: quantitative and qualitative perspectives. *Perspectives on Sexual and Reproductive Health*, 37, 110–118.

Finer, L. B., Frohwirth, L. F., Dauphinee, L. A., Singh, S., & Moore, A. M. (2006). Timing of steps and reasons for delays in obtaining abortions in the United States. *Contraception*, 74, 334–344.

Foster, D. G., Jackson, R. A., Cosby, K., Weitz, T. A., Darney, P. D., & Drey, E. A. (2008). Predictors of delay in each step leading to an abortion. *Contraception*, 77, 289–293.

France 24. (2012, October 26). France's lower house approves free abortions bill. Available: http://www.france24.com/en/20121026-french-lower-house-passes-bill-fully-reimburse-abortions-contraception-health-free

Guttmacher Institute. (2013). *State policies in brief: Restricting insurance coverage of abortion*. New York: Author. Available: http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf.

Harris, L. H., Cooper, A., Rasinski, K. A., Curlin, F. A., & Lyerly, A. D. (2011). Obstetrician-gynecologists' objections to and willingness to help patients obtain an abortion. *Obstetrics and Gynecology*, 118, 905–912.

Harris, L. H., Debbink, M., Martin, L., & Hassinger, J. (2011). Dynamics of stigma in abortion work: findings from a pilot study of the Providers Share Workshop. *Social Science & Medicine*, 73, 1062–1070.

Henshaw, S. K., & Finer, L. B. (2003). The accessibility of abortion services in the United States, 2001. *Perspectives on Sexual and Reproductive Health*, 35, 16–24.

Joffe, C. (1995). *Doctors of conscience: The struggle to provide abortion before and after Roe v. Wade*. Boston: Beacon Press.

Jones, R. K., & Finer, L. B. (2012). Who has second-trimester abortions in the United States? *Contraception*, 85, 544–551.

Jones, R. K., Finer, L. B., & Singh, S. (2010). *Characteristics of US abortion patients, 2008*. New York: Guttmacher Institute. Available: http://www.guttmacher.org/pubs/US-Abortion-Patients.pdf.

Jones, R. K., & Kavanaugh, M. L. (2011). Changes in abortion rates between 2000 and 2008 and lifetime incidence of abortion. *Obstetrics and Gynecology*, 117, 1358–1366.

Jones, R. K., & Kooistra, K. (2011). Abortion incidence and access to services in the United States, 2008. *Perspectives on Sexual and Reproductive Health*, 43, 41–50.

Norris, A., Bessett, D., Steinberg, J. R., Kavanaugh, M. L., De Zordo, S., & Becker, D. (2011). Abortion stigma: A reconceptualization of constituents, causes, and consequences. *Womens Health Issues*, 21, S49–S54.

O'Donnell, J., Weitz, T. A., & Freedman, L. R. (2011). Resistance and vulnerability to stigmatization in abortion work. *Social Science & Medicine*, 73, 1357–1364.

Towey, S., Poggi, S., & Roth, R. (2005). *Abortion funding: A matter of justice*. Boston: The National Network of Abortion Funds.

Sonfield, A., Alrich, C., & Gold, R. (2008). *Public funding for family planning, sterilization and abortion services, FY 1980–2006*. New York: The Guttmacher Institute. Available: http://www.guttmacher.org/pubs/2008/01/28/or38.pdf.

Van Bebber, S. L., Phillips, K. A., Weitz, T. A., Gould, H., & Stewart, F. (2006). Patient costs for medication abortion: Results from a study of five clinical practices. *Women's Health Issues*, 16, 4–13.

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