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Perceived and Insurance-Related Barriers to the Provision of Contraceptive Services in U.S. Abortion Care Settings

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Abstract

Background: Abortion facilities represent a potentially convenient setting for providing contraception to women experiencing unintended pregnancies. This analysis examines a range of factors that may act as barriers to integrating contraceptive and abortion services and documents abortion providers' perspectives on their role in their patients' contraceptive care.
Methods: Administrators from 173 large, nonhospital facilities that provide abortions in the United States responded to a structured survey between May and September 2009. We used chi-square tests to assess differences in categorical outcomes.
Results: Although the majority of U.S. abortion facilities offer a range of contraceptive methods on site, facility staff identified multiple barriers to full integration of the two services, in particular, insurance, patient, and cost barriers. Few of these perceived barriers, however, were associated with differences in the actual provision of most contraceptive methods. Specialized abortion clinics that do not accept health insurance were less likely to have highly effective methods, such as intrauterine devices and implants, on site. Facilities located in Medicaid states were more likely to accept both public and private health insurance for contraceptive services.
Conclusion: Increased access to contraceptive services during abortion care is one strategy for reducing repeat unintended pregnancy, and stakeholders at all levels - including abortion providers, insurance companies, and policy makers - have a role to play in achieving this goal.

Background

Half of U.S. women having abortions have already had at least one prior abortion (Jones, Finer, & Singh, 2008; Pazol et al., 2009). One way to help these women avoid future unintended pregnancies is to facilitate their access to contraception. The most effective contraceptives, such as the intrauterine device (IUD) and the implant, however, are typically the most expensive in upfront costs despite being highly cost effective over time (Mavranezouli, 2008). Cost can also serve as a barrier for women interested in using other highly effective methods such as the patch, pills, and the ring.

We recently conducted a study of contraceptive services at all U.S. health care facilities that provide 400 or more abortions per year; we dichotomized facilities by whether more than half - defined here as specialized facilities - or less than half – defined here as broad-based facilities - of patient services related to abortion. Our first publication indicated that virtually all these facilities integrate contraceptive services into abortion care, but that broad-based facilities provide a wider range of methods than do specialized abortion clinics (Kavanaugh, Jones & Finer, 2010).

Abortion patients may have limited access to certain contraceptive options during abortion care. Specialized abortion clinics are more likely to provide free samples of pills, patches, and rings than broad-based facilities are, but less likely to have these and the more expensive and effective IUD and contraceptive implant available at cost for abortion patients (Kavanaugh et al., 2010). The majority of abortions (70%) take place in these specialized clinics (Jones & Kooistra, 2011).

Most large abortion facilities (82%) accept insurance for contraceptive services, including Medicaid (69%), but specialized abortion clinics are less likely to do so than broad-based facilities (73% vs. 91%, respectively; Kavanaugh et al., 2010). Most women having abortions are poor or low income and, in 2008, 30% of abortion patients had private health insurance and 31% had Medicaid coverage (Jones, Finer, & Singh, 2010). These patterns suggest that many, and perhaps even a majority of, abortion patients obtained contraception at facilities that accept insurance. Perhaps more important, one third of abortion patients lack health insurance (Jones et al., 2010). For these women, cost may serve as a barrier and free contraceptive samples during abortion care may offer only a temporary solution, especially for those interested in hormonal and longer acting methods.

We were unable to identify any literature that examined strategies for integrating contraception and abortion services or reasons why certain abortion facilities may provide more comprehensive contraceptive services than others. General family planning providers, however, have identified insurance-related issues, such as reimbursement for contraceptive counseling time and improving coverage of contraceptive methods, as important strategies for improving patients' contraceptive use (Landry, Wei, & Frost, 2008). Although several leading health organizations highlight contraception as an integral component of abortion care (World Health Organization, 1997; National Abortion Federation, 2010; Planned Parenthood Federation of America, 2010), little is known about how abortion providers themselves perceive their role in the provision of contraceptive services. We hypothesized that logistical factors, such as limited resources (e.g., staff availability and training) and cost issues, play more of a role in determining the extent to which facilities incorporate contraceptive services into abortion care than does providers' desire to integrate the two services.

This article uses data from the previously mentioned study of contraceptive services at large abortion facilities to address two objectives. Our first objective was to identify and examine factors that may act as barriers to integrating contraceptive services in abortion facilities, with specific attention to insurance and cost issues. Our second objective was to examine associations between barriers perceived by administrators at abortion facilities and their ability to provide a range of contraceptive methods.

Methods

The data used in this article come from a larger, cross-sectional, mixed-methods study that documented contraceptive services in U.S. abortion care settings; sampling and data collection strategies have been previously described in detail (Kavanaugh et al., 2010). Briefly, a representative sample of 251 facilities was randomly selected from the universe of all nonhospital U.S. facilities with caseloads of 400 or more abortions per year (n = 569). Facilities were dichotomized by whether more than half - defined here as specialized facilities – or less than half - defined here as broad-based facilities – of patient services related to abortion. Administrators at these facilities received a self-administered survey between May and September 2009; 173 administrators completed the survey, for a response rate of 72%. This study was considered to be exempt by our organization's institutional review board.

Respondents provided information on the availability of specific contraceptive methods to abortion patients by selecting one or more of the following categories: For free/as a sample, at cost, through prescription, or by referral. We combined the free/sample and available-at-cost categories to represent on-site method availability. Survey respondents indicated 1 or more of 11 potential perceived barriers that might interfere with their ability to fully integrate contraception into abortion care at their facilities. Ten perceived barriers were grouped into 3 categories: Patient-level, facility-level, and insurance barriers. The 11th perceived barrier, "high costs for patients," remained separate in the analysis because it did not conceptually fit into any of the other barrier groups. Logistical barriers included a facility's location in a state that does not accept Medicaid for abortion services (defined here as "non-Medicaid state") versus a state that does ("Medicaid state") and its nonacceptance of any insurance for abortion services. We examined the impact of perceived and logistical barriers on contraceptive availability using chi-square tests to assess differences in categorical outcomes. We report results that were significant at $p < .05$.

Results

Overview of Facilities

Details of the demographic characteristics of the sample and the universe have been published elsewhere (Kavanaugh et al., 2010). Sixty-two percent of facilities in the sample performed at least 1,000 but fewer than 5,000 abortions per year, and the same proportion specialized in abortion services.[1] Although only 15 states use state funds to cover all or most medically

[1] Our final sample resembles the universe of U.S. nonhospital facilities that have caseloads of 400 or more abortions per year on all characteristics, with one exception: Planned Parenthood facilities were slightly overrepresented, comprising 27% of the population of abortion providers doing 400 or more abortions in 2005 but 36% of all facilities that participated in our study.

necessary abortions for low-income women enrolled in Medicaid,[2] almost half of the facilities in our sample were located in these states.

Availability of Contraceptive Services in Abortion Care Settings

Administrators agreed almost universally with the statement "providing contraceptive services as part of the package of abortion care is a priority at this facility" (99%, not shown in tables). Eighty percent of administrators indicated that abortion providers are responsible for linking abortion patients with general family planning providers for ongoing contraceptive care, and staff members at most abortion facilities are able to do so through prescriptions and referrals for methods that are not available on site.

Patterns of contraceptive provision at abortion facilities supported these statements. A majority of facilities provided a range of methods on site, either as free samples or at cost (Table 1). For most contraceptives, if the method was not available on site, staff members wrote prescriptions or referred patients to family planning facilities to ensure access to the method.

Perceived Barriers to Integrating Contraceptive Services Into Abortion Care

Although most facilities were able to offer a variety of contraceptive methods to abortion patients, more than three fourths indicated that insurance, patient-level, or high-cost issues presented at least a partial barrier to integrating contraceptive services into abortion care; 38% identified facility-level issues as a barrier (Table 2).

Although perceived barriers were common, they seemed to have limited impact on contraceptive availability and, in some cases, worked opposite to how one might expect (Table 3). Facilities in which insurance was perceived as a barrier, for example, were more likely to have rings and birth control patches available on site. An auxiliary analysis found that facilities that accept insurance for contraception were more likely to identify insurance-related barriers than those that did not (86% vs. 72%; $p = .05$). Respondents who perceived patient-related barriers to integration were more likely to report that injectable contraceptives were available on site. Respondents who perceived high method costs as a barrier to integration were less likely to report that the birth control patch was available on site, to provide emergency contraception in advance, or to offer immediate postabortion insertion of an IUD or implant.

Insurance and Contraceptive Services Within Abortion Care

We next examined associations between acceptance of insurance - private or Medicaid - and facilities' ability to offer a wide method mix. Facilities that accept insurance for contraceptive services were more likely to have injectables, emergency contraception, IUDs, and

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[2] Policy or court decisions in 17 states require the use of state funds to cover all or most medically necessary abortions for low-income women enrolled in Medicaid. Nonetheless, two states under court order to fund abortion services (Arizona and Illinois) report very few procedures. (Source: Sonfield A, Alrich C and Gold RB, Public funding for family planning, sterilization and abortion services, FY 1980-2006, Occasional report, New York: Guttmacher Institute, 2008, No. 38, Table 3.9, http://www.guttmacher.org/pubs/2008/01/28/or38.pdf, accessed March 16, 2010.) As a result, for analyses that distinguish between facilities in Medicaid and non-Medicaid coverage states, we do not include Arizona or Illinois in the former.

implants available on site for abortion patients. They were also more likely to offer abortion patients the option of receiving emergency contraception in advance or having the IUD or the implant inserted immediately after the abortion procedure (Table 4). Staff members at facilities that do not accept insurance for contraception were more likely to refer abortion patients for most of these same methods in addition to the vaginal ring (not shown).

Acceptance of insurance seems to increase the availability of more expensive contraceptive methods at specialized abortion facilities only. Abortion clinics that accept insurance were also more likely than those that do not to provide on-site access to birth control pills and rings at cost, in addition to IUDs and implants (data not shown). Staff members at specialized facilities refer abortion patients for a broader range of contraceptive methods than do broad-based ones, and those not accepting insurance are significantly less likely to provide or prescribe injectables and IUDs (data not shown).

Given that acceptance of insurance for contraception significantly increased facilities' ability to offer more expensive and effective contraceptive options, we examined several factors that could potentially influence this practice. We found that two interrelated issues affected whether or not a clinic accepted insurance for contraception: Whether a facility accepts any type of insurance for abortion services and whether it is located in a Medicaid state (Table 5).[3] Not surprisingly, facilities that accept insurance for abortion services were significantly more likely to accept insurance (both Medicaid and private) for contraceptive services in the context of abortion care, a pattern that was more pronounced among the specialized facilities than among the broad-based ones (data not shown).

Facilities located in non-Medicaid states were significantly less likely to accept any insurance for either abortion or contraception during abortion care. Ninety-two percent of facilities located in Medicaid states accept some kind of insurance for contraception, compared with 54% of those located in non-Medicaid states. Eighty-one percent of facilities located in Medicaid states accept private insurance for contraception, as compared with only half of facilities (49%) in non Medicaid states. The distinction between facilities located in Medicaid and non-Medicaid states is most pronounced for specialized abortion facilities, where only a minority in non-Medicaid states accepts any type of insurance for abortion or contraception and only 20% accept Medicaid for contraception. This distinct discrepancy is in contrast with the pattern at broad-based facilities, the majority of which accept both private and Medicaid insurance for abortion and contraception, whether they are located in a Medicaid state or not.

Discussion

Although the majority of U.S. abortion-providing facilities offer a range of contraceptive methods on site, staff at most of these facilities indicated multiple barriers to full integration of the two services. Facility-level barriers, which are related to staff time and training constraints and are some of the least-cited barriers, suggest that some facilities may need to revise clinic

[3] In addition to whether the facility was located in a Medicaid state and whether the facility accepted insurance for abortion, we examined the association between whether the facility was located in a state with high percentages of the population either covered by private insurance or Medicaid and whether the facility accepted insurance for contraception. No significant differences were found between facilities located in states with differing levels of population insurance coverage, with one exception: Facilities located in states with higher percentages of the population covered by private insurance were less likely to accept Medicaid insurance for contraception. These analyses do not appear in the tables.

protocols related to contraceptive counseling. Few of these perceived barriers, however, were associated with differences in the actual provision of most contraceptive methods.

We found that facilities that accept insurance were more likely to have a wider range of methods available on site. It is possible that facilities that do not accept insurance are not exposed to the kinds of insurance issues identified on our survey. Alternatively, facilities that accept insurance may also place more importance on providing certain methods and therefore be more likely to perceive insurance issues as barriers to reaching this goal. Facilities that identified the high cost of contraceptives as a barrier were less likely to provide immediate postabortion insertion of IUDs, a practice shown to be highly safe (Fox et al., 2011) and effective at preventing repeat abortion (Goodman, Hendlish, Reeves, Foster-Rosales, 2008).

This study found that abortion clinics that do not accept health insurance were less likely to have highly effective methods, such as IUDs and the contraceptive implant, on site. Abortion clinics likely have little reason to stock these more expensive methods for a patient population that is largely low income and cannot afford the out-of-pocket costs of these methods. This may be especially true at facilities that do not subsidize, cover, or provide any discount on costs, an interpretation supported by our finding that the more expensive methods are more likely to be available at cost at facilities that accept insurance.

It makes sense that facilities that accept insurance for abortion are more likely to accept it for contraception. More unexpected is that facilities located in Medicaid states are more likely to accept both public *and* private insurance for contraceptive services, probably because they are more likely to accept insurance for abortion services. A potential unintended consequence of restricting state Medicaid funds from covering abortion services is the decreased likelihood that facilities in these states will accept any insurance for contraceptive services. Facilities in non-Medicaid states are, not surprisingly, less likely to accept Medicaid for contraceptive services within the context of abortion care. These facilities are also less likely to accept private insurance for contraceptive services, possibly because there is little benefit from going through the trouble of setting up necessary structures for insurance billing and reimbursements (Kacanek, Dennis, Miller, & Blanchard, 2010) for, at best, one third of their abortion patients, especially when this same system cannot be used to bill Medicaid for abortion or contraceptive services.

Specialized abortion clinics and more broad-based facilities face different challenges to integrating contraceptive services into abortion care. It may be unrealistic to advocate that all specialized abortion clinics incorporate comprehensive contraceptive services into their primarily single-service setting, because issues such as increased stigma and often burdensome travel distances may make this an unappealing setting for many abortion patients (Cohen, 2007). Rather, some clinics may better serve their abortion patients by referring them to comprehensive reproductive health care facilities for ongoing contraceptive care. The majority of facilities that we surveyed routinely provide referrals for ongoing contraceptive care, and the high percentage of abortion clinics that report this practice is encouraging. Although more broad-based facilities may have the resources and infrastructure to provide both contraception and abortion services, government-imposed barriers may inhibit their ability to provide both services seamlessly. This is especially true for those patients who rely on government assistance to pay for contraception.

Our findings must be interpreted in light of some study limitations. We relied on staff members' reports of contraceptive services at their facilities, and so our data, especially regarding facility-level barriers, may be biased toward socially desirable responses. Because this was a cross-sectional survey of providers, we are not able to determine the direction of the causal relationship, if any, between the perceived barriers among respondents and contraceptive

availability among facilities. In addition, administrators at abortion facilities identified patient-related barriers, but the extent to which abortion patients themselves perceive these same factors as obstacles is unknown, and research into their perspectives is warranted.

Conclusion

Most women obtaining abortions in the United States are poor or low income (Jones et al., 2010). Although nearly two thirds have some type of health insurance, this analysis suggests that a substantial minority do not have the option of using that insurance to pay for contraception offered by abortion providers. One third of abortion patients have no health insurance, and those interested in hormonal methods may be limited to 1 or 2 months of methods supplied as free samples. Long-acting reversible contraceptives, such as the implant and the IUD, require less user involvement and less frequent contact with clinicians and are thus ideally suited for broader integration into the abortion care setting. However, this can happen only if cost and insurance barriers are removed. For more user-dependent methods, such as the pill, ring, and patch, providers at facilities where methods are not available on site should be encouraged to refer abortion patients elsewhere for contraceptive services.

Increased access to contraceptive services during abortion care is one strategy for reducing repeat unintended pregnancy and repeat abortion, and stakeholders at all levels have a role to play in achieving these goals. Abortion providers should continue to be encouraged to make contraceptive methods available to their patients through some avenue - on site, through prescription, or by referral. Insurance companies need to make it easier for abortion providers to participate in their plans by minimizing administrative burdens associated with seeking reimbursement for services. Finally, policy makers interested in reducing unintended pregnancy and abortion rates should focus more on facilitating access to contraceptive services and less on creating barriers to abortion.

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Author Descriptions

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Table 1: Availability of Contraceptive Methods in US Abortion Care Facilities (n = 173)

	How Methods are Provided During Abortion Care (%)					
	On-site			Prescription	Referral	Not available
	Sample, at Cost or Both	Sample Only (Free)	At Cost Only			
Methods						
Birth control pills	90	58	15	4	0	6
Contraceptive injectable	80	6	72	3	4	13
Vaginal ring	71	42	21	15	1	13
Emergency contraception	62	6	47	13	4	22
Intrauterine device	59	1	56	2	17	22
Birth control patch	51	21	24	22	1	27
Contraceptive implant	28	0	17	2	24	46

Note: Methods available by prescription are not available on-site. Methods available through referral are not available on-site or by prescription. Methods that are not available are not available on-site, by prescription or referral.

Table 2: Percent of Facilities that Report Specific Barriers to Integrating Contraceptive Services into Abortion Care

	Total %
Insurance (n = 158)	**82**
Selective coverage of methods by insurance companies	74
Inadequate reimbursement from payors	59
Authorization/pre-approval required for certain methods	54
Current protocols do not allow same-day insertion for certain methods	52
Patients must seek own reimbursement for contraceptive services	44
Patient-level (n = 170)	**81**
Patients are anxious about the abortion procedure	74
Patients seem overwhelmed with information	62
Low patient interest	47
High cost (n = 163)	**79**
High costs for patients	
Facility level (n = 167)	**38**
Too little time for contraceptive education and provision	32
Clinicians need more training or experience for some methods	16

Note: The number varies among barrier groups due to differences in item nonresponse.

Table 3: Percent of Facilities that Report Providing Contraceptive Methods On Site and Percent That Use Selected Service Provision Strategies, by Perceived Barriers to Integrating Contraceptive Services into Abortion Care

	Insurance Barriers (n = 158)			Patient Barriers (n = 170)			High Cost Barrier (n = 163)			Facility Barriers (n = 167)		
	Yes	**No**	**p**	**Yes**	**No**	**p**	**Yes**	**No**	**p**	**Yes**	**No**	**p**
On-site methods												
Birth control pills	90	93	0.64	89	97	0.16	90	94	0.45	94	89	0.33
Contraceptive injectable	83	79	0.57	**83**	**67**	**0.03**	81	77	0.59	86	78	0.19
Vaginal ring	**75**	**54**	**0.02**	72	67	0.52	71	71	1.00	72	72	0.99
Emergency contraception	61	75	0.16	64	58	0.53	61	74	0.16	66	61	0.56
Intrauterine device	65	61	0.64	63	49	0.13	59	65	0.54	58	61	0.67
Birth control patch	**55**	**32**	**0.03**	51	49	0.79	**46**	**71**	**0.01**	50	52	0.86
Contraceptive implant	33	18	0.11	29	27	0.89	26	38	0.17	27	30	0.62
Provision strategies												
Advanced emergency contraception	55	46	0.43	52	49	0.73	**46**	**74**	**<0.001**	48	55	0.36
Immediate post-abortion long-acting reversible contraception insertion	33	46	0.18	34	27	0.44	**30**	**50**	**0.02**	30	35	0.48

Table 4: Percent of Facilities That Report Providing Contraceptive Methods On Site and Percent That Use Selected Service Provision Strategies, by Acceptance of Insurance and Type of Facility

	Facility Accepts Insurance for Contraceptive Services		
	Yes	**No**	**p**
All facilities (n = 173)			
Methods			
Birth control pills	89	92	0.53
Contraceptive injectable	**85**	**69**	**0.02**
Vaginal ring	72	69	0.75
EC	**68**	**48**	**0.02**
Intrauterine device (IUD)	**69**	**37**	**<0.001**
Birth control patch	51	50	0.92
Contraceptive implant	**38**	**4**	**<0.001**
Provision strategies			
Advanced EC	**62**	**26**	**<0.001**
Immediate post-abortion LARC insertion	**38**	**21**	**0.04**
Broad-based facilities* (n= 65)			
Methods			
Birth control pills	87	100	0.44
Contraceptive injectable	85	50	0.07
Vaginal ring	64	75	0.65
EC	75	50	0.26
IUD	74	50	0.30
Birth control patch	57	75	0.49
Contraceptive implant	46	25	0.42
Provision strategies			
Advanced EC	75	67	0.73
Immediate post-abortion LARC insertion	46	50	0.87
Specialized abortion facilities* (n= 108)			
Methods			
Birth control pills	92	92	0.98
Contraceptive injectable	85	71	0.08
Vaginal ring	80	69	0.20
EC	59	48	0.24
IUD	**64**	**35**	**<0.01**
Birth control patch	44	48	0.69
Contraceptive implant	**31**	**2**	**<0.001**
Provision strategies			
Advanced EC	**48**	**23**	**0.01**
Immediate post-ab LARC insertion	29	19	0.23

Abbreviations: EC, emergency contraception; IUD, intrauterine device; LARC, long-acting reversible contraception

Note: Facilities that accept insurance are those that indicated that they accept Medicaid and/or private insurance

* Broad-based facilities are facilities in which <50% of services are related to abortion care. Specialized abortion facilities are facilities in which ≥50% of services are related to abortion care.

Table 5: Percent of Facilities That Accept Insurance for Contraceptive Services According to Type of Facility and Type of Insurance, by Whether Facility Accepts any Insurance for Abortions; and by Whether Facility is Located in a State Where Medicaid Funds can Cover Abortion Services

	Total	Facility located in state with Medicaid funding for abortion		
	%	Yes	No	p
All facilities (n = 173)				
Accepts either Medicaid or private insurance for abortion	71	**97**	**52**	**<0.001**
Accepts either Medicaid or private insurance for contraception	70	**92**	**54**	**<0.001**
Accepts at least Medicaid for contraception	52	**76**	**34**	**<0.001**
Accepts at least private insurance for contraception	62	**81**	**49**	**<0.001**
Broad-based facilities* (n = 65)				
Accepts either Medicaid or private insurance for abortion	89	**100**	**72**	**<0.001**
Accepts either Medicaid or private insurance for contraception	94	**100**	**84**	**0.01**
Accepts at least Medicaid for contraception	83	88	76	0.23
Accepts at least private insurance for contraception	85	88	80	0.42
Specialized abortion facilities* (n = 108)				
Accepts either Medicaid or private insurance for abortion	60	**94**	**45**	**<0.001**
Accepts either Medicaid or private insurance for contraception	55	**82**	**43**	**<0.001**
Accepts at least Medicaid for contraception	33	**63**	**20**	**<0.001**
Accepts at least private insurance for contraception	49	**73**	**38**	**<0.01**
Facilities accepting either Medicaid or private insurance for abortion (n = 123)				
Accepts either Medicaid or private insurance for contraception	91	93	88	0.37
Accepts at least Medicaid for contraception	67	**77**	**53**	**0.01**
Accepts at least private insurance for contraception	84	83	84	0.86

* Broad-based facilities are facilities in which < 50% of services are related to abortion care. Specialized abortion facilities are facilities in which ≥ 50% of services are related to abortion care.