Did Policy Change Work? 
Oregon Women Continue to Encounter Delays in Medicaid Coverage for Abortion

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ABSTRACT: Women in poverty experience greater delays in the process of seeking abortion. Timely access to both safe abortion care and early prenatal care reduces morbidity and mortality among pregnant women. This article examines the impacts of a policy change intended to facilitate poor women’s applications for pregnancy-related Medicaid (a federally funded, state-administered health coverage programme for the poorest Americans), in Oregon (Western U.S.). The mixed-methods data from this applied anthropology study demonstrate that though health coverage waiting times grew shorter on average, poor women and the clinic staff who cared for them continued to perceive delays in obtaining Medicaid coverage for abortion. Implementation of the Affordable Care Act in the U.S.A. (aka Obama-care) is now thought to be contributing to a return to greater delays in accessing prenatal care and abortion. More research and advocacy are needed to improve access to reproductive health care through state Medicaid programmes.

KEYWORDS: abortion access, abortion delays, Affordable Care Act, health disparities, Medicaid, Medicaid waiting time, Oregon Health Plan, reproductive health

Introduction

As the United States government, and health-care consumers, begin to navigate the previously un-unknown landscape of mandatory universal health-care coverage (to be applied for and paid for by the recipient), the importance of examining the experiences of low-income American women who have long been eligible for the closest thing to national health care in the U.S., Medicaid, cannot be underestimated. For those who already know the process of applying for, and then waiting to hear about, government-subsidised emergency medical care first-hand, the prospect of expanding mandated health coverage may raise the spectre of continued health-care delays. It is well-documented that pregnant women in poverty already encounter bureaucratic and economic obstacles while seeking reproductive health care in the United States, particularly when in need of abortion care (Boonstra 2007; Ellison 2003; Henshaw et al. 1999; Ostrach and Cheyney 2014). This is true even when state Medicaid programmes include provisions to cover abortion services for eligible women (Kiley et al. 2010).

Though access to safe abortion care is a recognised international public health priority for reducing morbidity and mortality among women of reproductive age, Medicaid-eligible and other poor women in the United States are disproportionately affected by barriers to care, increasing health risks for these already vulnerable populations (Barot 2011; Boonstra 2007; Chopra et al. 2009; Grimes et al. 2006; Hess 2013). Requirements related to applying for coverage for abortion in the few remaining states where it is covered by Medicaid are strong determinants of abortion accessibility for low-income women, overall (Foster et al. 2008; Jones and Weitz 2009), making it critical that researchers, advocates and policymakers seek to under-
stand women’s perceptions of the process of applying for subsidised state or national health care.

This article presents data collected following a policy change in Oregon (Western United States) that was intended to shorten waiting times for state Medicaid coverage for low-income pregnant women, as a follow-up to the author’s earlier findings documenting obstacles to abortion posed by delays in this Medicaid programme (Ostrach and Cheyney 2014). The study described here also builds on earlier research about women’s experiences with obstacles to abortion in the U.S. and internationally (Henshaw et al. 1999; Ostrach 2012) and women’s experiences with navigating Medicaid systems to access abortion (Foster et al. 2008; Jones and Weitz 2009; Ostrach 2012; Ostrach and Cheyney 2014). Through the follow-up study, the author investigated whether women in Oregon continued to perceive or experience delays in the process of applying for Oregon Health Plan coverage (the state Medicaid programme, also called OHP) for abortion care, beginning one year after the state Department of Human Services (DHS) transmitted a policy directing all OHP eligibility workers to prioritise pregnancy-related applications and expedite them within one to two business days.

The transmittal (#SS-AR-11-007) clarified the state agency’s existing (but little-known and un-enforced) policy of expediting pregnancy-related applications. Moreover, for the first time, it stipulated that each office receiving OHP applications should implement a system for ensuring compliance with the expedition policy. These changes represented a research-based policy reform, resulting from a legislative advocacy campaign, the result of a collaborative effort between the author, an applied medical anthropologist and her colleague Jessica Matthews, who was then a student in a master’s public health programme (MPH) at the same university.

After working with the author to disseminate the findings of the earlier study in 2010, the MPH student (JM) developed a legislative internship with a member of the Oregon Legislature’s health-care committee, designed to facilitate her use of the findings on Medicaid delays affecting low-income pregnant women, along with her own background in maternal–child health, to advocate for improved access to Medicaid coverage. We strategised to develop a plan to talk with legislators and state health plan administrators about the negative public health impacts of delaying prenatal care for women in poverty, and to illuminate the increased health care and education costs to the state that could result from Medicaid delays that prevent women at highest risk for low-birth-weight and preterm births from getting prenatal care in a timely manner. Together, we determined that talking only about abortion delays and obstacles would not be as politically convincing or popularly effective with the various health programme and health policy officials at the state level, as would be talking about the links between late entry to prenatal care and increased risks of perinatal complications and poor outcomes for women in poverty and their children.

This strategy worked – JM was able to gain the support of a key legislator who had helped to create the Oregon Health Authority, an entity that oversees the state agency which processes Medicaid proposals and administers the coverage. Through this legislator’s office, she was able to lobby successfully for the Oregon Health Authority to issue the policy clarification transmittal, just one year after the findings from the author’s earlier study were publicly presented.

While the wording of the 2011 policy transmittal could strike the reader as vague, one of the great values of the terminology used was that by specifying as its target ‘pregnancy-related’ applications, this attempt to expedite Medicaid coverage for low-income pregnant women thus stood to benefit both poor women planning to carry to term, in need of prenatal care, as well as women seeking abortion care who could not otherwise afford it.

The follow-up study that produced the data presented here was carried out in 2012 at the same clinic where the author collected the data for the earlier study (Ostrach and Cheyney 2014). It explored whether the policy change shortened OHP waiting times for clinic patients from a quantitative standpoint, revisited clinic staff member’s perceptions of obstacles, and explored whether clinic staff who work most closely with pregnant women seeking Medicaid coverage for abortion care did or did not notice a reduction in Medicaid waiting times following the policy change. In that sense, this follow-up project was an evaluation of the efficacy of an evidence-based advocacy effort based in applied anthropology, geared towards policy at the state level.

The findings offer important lessons about whether and how abortion access improved in Oregon, how women continued to perceive obstacles, and in what areas advocacy is still needed. The question of how the OHP application process affected women seeking abortion at this clinic was particularly relevant, as the earlier research found that 70 per cent of women seeking care at the clinic were likely OHP-eligible by income, while only 35 per cent were covered by OHP at the time of their abortion (Ostrach and Cheyney 2014).
Thus, this applied medical anthropology study aimed to offer abortion providers, legislators, state health programme administrators and reproductive health advocates in Oregon and elsewhere relevant and recent information about women’s experiences with obstacles to abortion, and especially to examine the apparent outcomes of a state-level Medicaid policy change based on earlier research. Access to abortion services is an important concern for all women of reproductive age, and for doctors and others who provide reproductive health services, as ensuring access to safe, legal abortion is a key factor in reducing morbidity and mortality for pregnant women worldwide (Barot 2011). Moreover, with the current implementation of the Affordable Care Act (United States Department of Health and Human Services, http://www.hhs.gov/healthcare/facts/timeline/index.html) at the state level across the United States, and its intersections with, and effects on, Medicaid income eligibility thresholds and application processes, the question of how Medicaid and other U.S. government-based health-care programme guidelines are applied to low-income pregnant women is increasingly relevant in both policy and advocacy arenas.

Methods

The follow-up study was conducted over a two-month period (July–August 2012) at an abortion clinic in western Oregon that had been the main provider of abortion services for women from northern California to Portland, Oregon (a distance of many hundreds of miles) for many years. As the only provider of second trimester abortion care outside of Portland at the time of both the 2009–2010 and 2012 studies, this clinic served women from all over Oregon and surrounding states. The clinic described herein was also the site of the above-mentioned earlier study that first identified obstacles to abortion, and especially to examine the apparent outcomes of a state-level Medicaid policy change.

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Following IRB approval for the ethical and non-coercive treatment of human subjects, and using opportunistic and convenience sampling (Bernard 2006), the author compiled quantitative survey and demographic data, collected by clinic staff for the clinic’s own internal quality assurance purposes, from women arriving at the clinic for abortion throughout the study period, for a final number of 111 women seeking abortion. The clinic also distributed interview recruitment forms to all women seeking abortion during July and August 2012. To contextualise the quantitative data further, the author engaged in participant observation (Bernard 2006) during shifts as a paid medical assistant and translator. The author also spent non-clinical hours (when no patients were in the building) talking with fellow clinic workers who explicitly gave verbal assent for this. The follow-up study thus includes qualitative data from five clinic employees, and from one formal in-depth, triangulation interview conducted with a woman who obtained abortion care at the clinic during the study and who had applied for OHP for both the current and a previous pregnancy.

Unfortunately, of the more than twenty women who agreed to be contacted to schedule an interview during the course of the study, only one woman had in fact applied for OHP and was able to follow through to schedule and participate in an interview during the IRB-approved time period of the follow-up study. Because of the extremely low number of women seeking care who were interviewed, this one interview with a woman who applied for OHP and sought abortion care should be regarded as valuable essentially as a case study and for triangulation, rather than being necessarily representative of the overall qualitative perceptions of women seeking care.

Participant observation was conducted with clinic staff and the doctor who performed all surgical procedures. Through this method, the author documented clinic employees’ perceptions of their patients’ (de-identified) experiences with the process of applying for OHP, following the policy change. The author’s positionality as an insider in the clinic (where she worked as a medical assistant, surgical assistant, counsellor and translator during both the earlier study and during the follow-up) facilitated data collection and analysis. In combination, informal interviews with clinic staff, participant observation in the clinic and this case study, provided ample opportunity to elicit stories of women’s experiences with the OHP application process, and to explore in detail clinic workers’ sense of the Medicaid application process, since the 2011 policy change.

While any given patient knows her own OHP experience, clinic staff who see hundreds of women that have applied for OHP to cover their procedures can address their sense of patterns in the ease or difficulty of getting Medicaid coverage for abortion in a timely manner. At the time of the case study interview, and in the multiple informal conversations with clinic staff, the author used a list of topics to prompt, probe and clarify particular aspects of women’s experiences of applying for OHP. Using modified Grounded Theory data collection and analysis techniques (Charmaz and Antony 2010) by beginning with a very general open-ended question (e.g., ‘What was the process of applying for OHP like for you?’ or ‘What do you no-
tice about what patients’ experiences with OHP are?”) participants were encouraged and supported in relating their own narratives, with minimal interruption to clarify or ask for an expanded explanation.

Transcripts, as well as auto-ethnographic personal daily notes and participant-observation field notes written up by the author after each day in the clinic, were analysed through an iterative qualitative analysis coding process known as modified Grounded Theory (Charmaz and Antony 2010), in which the author repeatedly reviewed each set of qualitative data three to five times, to identify recurring themes and patterns. Recurring key concepts, ways of describing a phenomenon, and repeated terms such as ‘waiting period’, ‘case worker’, and ‘eligibility’ were visually marked in different colours, and the colour-coded transcripts were then visually reviewed in order to map and organise index cards used to identify and elucidate the apparent relationships between various factors. These mapped cards were then used to contextualise and inform findings from quantitative data, to create an overall analytical picture of the participants’ reported lived experiences with key aspects of abortion-seeking, related to Medicaid need and application/enrolment.

Descriptive statistics were also generated from the quantitative data to provide a picture of the respondent population’s demographic and socioeconomic characteristics, and to measure specific aspects of self-reported OHP application and approval timelines, as well as women’s perceptions of other known barriers to abortion access. The sample sizes in the follow-up study were representative of typical patient volume for this clinic during summer months, and offered a sufficient amount of mixed-methods data to discern patterns and trends in the responses, given the focused nature of the research question.

Results

On average, low-income pregnant women in Oregon who needed OHP coverage to obtain timely abortions waited a shorter time for eligibility confirmation a year after the 2011 policy change than they had previously. Perceptions of difficulties and delays in applying for OHP, or in paying for the procedure, also decreased. Most women, however, still waited longer than they should have had to, under the then-recently issued policy change.

Demographic Profiles of Participants

For the most part, the demographic profiles of follow-up study respondents closely mirrored those identified in the earlier study, and also closely matched recent national profiles of women obtaining abortions in terms of age, educational attainment, parity, previous abortions and marital status (Table 1, AGI 2011). One interesting departure from national data trends was in the percentage of abortions performed in the second trimester. Although the average gestation upon arrival at the clinic was only six weeks, a lower proportion of abortions in the follow-up study were performed in the first trimester than the national average (70 per cent versus 88 per cent, AGI 2011).

This could be explained by the clinic’s role as the only provider of second-trimester abortions between Northern California and Portland, Oregon, at that time (the clinic has since closed, and only early abortion is now available in that town). Women who may have sought first-trimester care elsewhere, and were then delayed by obstacles to access or other factors, may have ultimately arrived at the study clinic seeking care when their pregnancies were already in the second trimester, as was the case for 30 per cent of respondents. Any woman in most of the state of Oregon, and in parts of surrounding states, who encountered delays and obstacles in obtaining abortion care such that they passed the first trimester mark, was very likely to end up at the clinic where study data was collected, if she succeeded in obtaining an abortion at all, thus explaining the comparatively higher ratio of second to first trimester abortions. Moreover, this trend is particularly interesting in light of this article’s emphasis on Medicaid policies, as Medicaid-eligible women are statistically more likely to seek second trimester abortion care, nationally (Jones and Weitz 2009), often because of Medicaid-related delays.

Clinic staff that participated in informal conversations and were present during participant observation represented a wide range of ages, educational attainment, race/ethnicity, marital status and parity. Of interest to readers may be the fact that at least one clinic employee who contributed her perceptions of the OHP application process as it appeared to affect patients had herself been a patient at the clinic years earlier, and recalled what applying for pregnancy-related OHP had been like when she did it.

Poverty, OHP Eligibility and Waiting Times

Of particular relevance, given Medicaid eligibility factors, is the fact that the majority of respondents were living in or near poverty. Despite the similarity in income and poverty levels in both this study and the earlier one, just 25 per cent of the women in the follow-up study reported that the cost of abortion pro-
cedures was a ‘very or somewhat challenging’ obstacle, compared to 42 per cent prior to the policy change – suggesting to the author that fewer women found the cost to be a challenge, because more women were able to get Medicaid coverage to pay for the procedure in a timely manner. A higher proportion of women in the follow-up study were also aware that OHP would pay for the abortion, and almost twice as many were covered by OHP at the time of the abortion.

Half as many women completing surveys reported that difficulty with OHP was a ‘very or somewhat challenging’ barrier, suggesting that the research-based advocacy in the intervening years that led to the policy change can be assumed to have achieved a measure of success. While 21 per cent of respondents in the follow-up study who applied for OHP did receive confirmation of their eligibility within the recently reiterated timeline of one to two business days, 79 per cent of women who should have been able to get OHP approval within one to two business days actually waited longer.

As a case study of both the ‘before’ and ‘after’ of Medicaid application policies for pregnant applicants, the woman who participated in an interview related experiences that echo many of these trends. ‘Marie’ was a twenty-one-year-old single mother of a toddler, living in the same county where the clinic was located, attending community college and working as a caregiver at a nursing home. She applied for OHP when she was first pregnant with her young son, prior to the policy change. Marie reported that she went to the DHS office at that time with all her paperwork but had to return ‘three or four times’ before her eligibility was confirmed and she could obtain prenatal care. In violation of even the existing policy at the time, Marie was warned by caseworkers to expect a delay, ‘I was told my application would be processed in the order it was received’. Although she had originally applied for OHP during the first trimester of a pregnancy she decided to carry to term, Marie’s OHP coverage prior to the policy change did not begin until she was fourteen weeks pregnant – already in the second trimester, and in violation of international recommendations for early access to prenatal care as part of preterm birth/low birth weight prevention efforts.

As someone who receives no child support and earns less than U.S.$10,000.00 per year, Marie was exactly the kind of Oregonian that OHP is intended to help, but her experiences with the process of applying were initially frustrating. However, Marie mentioned that she began receiving regular updates on her ongoing coverage and benefits (by mail) around the time of the 2011 policy change. When Marie learned she was pregnant again following a birth control failure early in the summer of 2012, she was able to get in contact with her case worker and re-confirm her OHP eligibility very quickly, ‘Oh it was no problem ... I just had to tell my caseworker I was pregnant [again]’. In Marie’s case, having her information already in the DHS system likely contributed to the ease with which she was able to re-qualify, but she stated she believed it had become easier to navigate eligibility requirements, following the policy change.

In addition, other aspects of Marie’s narrative reinforced earlier findings (Ostrach and Cheyney 2014) that the threat of escalating domestic violence may influence women’s feelings of desperation to seek abortion care quickly, and that, in turn, delays and obstacles to abortion access affecting women dealing with intimate partner violence may expose them to more danger. Due to his threats and verbal abuse, Marie reported she chose to tell her then-partner that she had had a miscarriage, and cut off all contact with him after the pregnancy was terminated. Marie expressed that being able to re-qualify for OHP rapidly upon learning of her new pregnancy was a relief, because of the violence she feared would have continued along with the pregnancy. For many women in poverty, access to abortion care via Medicaid coverage may seem like one of the only ways out of an abusive situation, or a way to prevent subjecting a new baby to escalating abuse. At the intersections of structural violence and interpersonal violence that affect women in intimate partner violence situations, a Medicaid-covered abortion may be one of few available resources to enact their agency.

Moreover, a week of waiting for health coverage may not sound like a long time to some readers, but in situations of unwanted pregnancies, a week can mean the difference between needing a first or second trimester abortion (with the accompanying additional clinic visits, increased time off work, increased need for childcare, etc.), or can even delay a woman past the legal cut-off for obtaining an abortion at all.

Among women who reported on surveys that the OHP application process was ‘very or somewhat challenging’, the wait time for OHP approval was longer than the average, and proportionally fewer women who reported that applying for OHP was challenging also reported that they perceived adequate social support while seeking care. Participant observation in the clinic, and interviews and conversations with clinic staff contextualised and affirmed the implications of these findings – women who perceived more difficulty getting OHP likely waited longer for OHP coverage confirmation, and appeared
to have had less social support to help them overcome obstacles.

In addition to a unanimous sense that the 2011 policy change had simplified and largely sped up the process of getting OHP for their patients, some clinic staff also perceived another, unintended, consequence of the policy change: that, to the extent the policy of expediting pregnancy-related applications was succeeding, it was at the expense of clinic revenue. Both ‘Dr Liam’, who performed all surgical procedures and owns the clinic, and ‘Melanie’, the manager responsible for billing and tracking insurance payments, noticed a relative increase in the number of first-trimester procedures performed for women on OHP, who might have otherwise paid cash for early abortion care rather than wait the previously typical two to three weeks for OHP.

In their view, the improvement in DHS policy meant that the clinic was subsidising Medicaid patients’ procedures without the prior level of revenue from cash-paying clients to balance it out. In fact, DHS reimburses abortion providers at a rate far below the market price for such procedures, and pays out the same amount regardless of gestation or the number of visits a procedure requires, at an amount that is far less than the total cost of overhead, payroll and supplies per procedure. Nonetheless, Melanie viewed the policy change positively, and reported that she began seeing patients who were able to get their OHP coverage confirmed the same day or the next day, within just a few days of the policy change.

‘Monique’, the clinic receptionist, estimated it was typically a ‘one to two week wait’ for OHP and stated, ‘it’s not uncommon for DHS to drag their feet’. However, Monique reported that women often arrived at the clinic for their appointments saying they were told by a DHS case worker that the OHP application would be processed the same day, only to have Monique find she was unable to confirm them as eligible in the DHS online system. In such cases, Monique sent patients directly back to DHS, and told me that when women are ‘assertive and advocate on their own behalf at DHS’, the application is sometimes processed on the spot. Needless to say, this still means an additional trip to DHS, potentially requiring women to reschedule their appointment(s).

Interestingly, ‘Dawn’, a fairly new medical assistant who began working at the clinic only after the 2011 policy change, felt that OHP, ‘must be easy to get, because so many women who come in are on it’. But she also mentioned that her sister had applied for OHP while pregnant, and waited ‘several months’ to hear if she was approved. Another medical assistant, ‘Delilah’, mentioned, ‘It definitely takes over a week for OHP approval. I had a patient recently who was told by DHS that her application would not be processed within a week, and she had to reschedule her appointment’.

Several medical assistants shared stories about women who had hoped to have a medication (non-surgical) abortion (for which there was a strict cut-off of about seven weeks gestation at this clinic) and who, due to OHP delays, ended up being too far along and had to have surgery instead. Overall, clinic staff reported what the surveys indicated, that the OHP application process appeared to have improved somewhat and moved more quickly than it did prior to the policy change, but that many women still experienced delays.

One specific county appeared, from survey and qualitative data, to be a particularly difficult place for women to benefit from the policy change. The county where the clinic is located is among the five most populous in the state (Oregon Demographics 2012), and was home to just over half of study participants. This county also appeared to be the least compliant with the new policy. Fifty percent of women who reported that applying for or waiting for OHP was a ‘very or somewhat challenging’ obstacle lived there. More women in this county, as compared to the overall sample, were denied OHP, waited three weeks or longer, waited for two to three weeks, waited more than a week, or even just waited longer than the stipulated timeline of one to two business days. Strikingly, 59 per cent of women in this county who applied for pregnancy-related OHP waited longer than state policy mandates, compared to 37 per cent in the overall sample.

It is worth noting that the county in question is generally seen as more liberal than many other parts of the state, and has a specific maternal–child health programme ostensibly dedicated to expediting OHP applications for pregnant women (Prenatal Assistance 2012). Yet efforts to improve access to OHP for low-income pregnant women seemed not to have benefitted poor women seeking abortion. The policy transmittal that, in the preceding year, mandated case workers to prioritise pregnancy-related OHP applications clearly directed eligibility workers to prioritise such applications and process them within one to two business days. Apparently, this county did not get the message, or failed to set up a system for doing so effectively.

In addition, the qualitative findings reaffirmed the importance of perceived social support from partners, family or friends, in helping women overcome logistical obstacles encountered in the OHP application
process. For example, Marie was clear that receiving support from her family was important, ‘the biggest help was talking to my mom and grandma about it’. Forty-nine percent of respondents indicated social support helped them overcome obstacles to abortion access. In the qualitative sample, clinic staff and women seeking care agreed that social support helps women overcome obstacles.

Discussion and Conclusions

Low-income pregnant women in Oregon continued to experience delays in obtaining Oregon Health Plan coverage, despite a 2011 policy change intended to shorten waiting times and facilitate the process. When the official policy stipulated that pregnancy-related applications must be processed within one to two business days, and that each office must have a system in place to ensure that pregnancy-related applications are expedited, why was this not taking place a year later? The persistent delays and difficulties in the application process affected an already vulnerable population: low-income pregnant women. While the improvements in the OHP application are to be celebrated, the areas in which progress is still lacking, or even where ground has been lost, need to be closely examined and addressed.

Many pregnant women in Oregon waited too long for OHP coverage that would allow them to obtain a timely abortion or prenatal care. Only 21 per cent of women who applied for OHP following the policy change received confirmation of coverage within the stipulated timeline, and this number was even lower in the county where the clinic is located. If a policy is only fully realised for one-fifth of an affected population in a given sample, if 79 per cent of women who should have been able to get OHP within one to two business days waited longer than that, what was the lasting value of legislative efforts to hold DHS accountable for the health-care coverage it is tasked with providing? Legislators who work to hold DHS accountable on behalf of low-income Oregonians evidently have more work to do.

The necessity of rapid OHP coverage was particularly evident at this clinic, which was long responsible for providing second-trimester abortion care for any woman who needed an abortion after twelve weeks gestation, and for whom this clinic was closer than Portland or Northern California. This explains the comparatively higher proportion of second-trimester procedures performed at the clinic during the study – a proportion of the 30 per cent of procedures performed for women in the second trimester were likely sought by women who tried to get first-trimester care elsewhere, and were delayed by various obstacles to access. With women in the second trimester of a pregnancy at greater risk for complications and for soon being too far along to obtain a legal abortion, delays of even a few days in confirming OHP coverage and/or reaching a qualified provider can be critical. A greater proportion of women who had to wait longer for OHP saw the application process as ‘very or somewhat challenging’. Women who reported that OHP was a ‘very or somewhat challenging’ obstacle were also less likely to report receiving adequate social support.

One notable shift following the policy change was seen in the percentage of women who viewed the cost of the abortion procedure as ‘very or somewhat challenging’, to 25 per cent, from 42 per cent. Qualitative data suggested that, overall, the OHP application process had become easier and/or faster, saving money for some women who would otherwise have paid out of pocket. This seems likely when viewed alongside the finding that more women were aware that OHP would pay for abortion, and more women were covered by OHP, from 2009 to 2012. Finally, the proportion of women who saw the OHP process as a ‘very or somewhat challenging obstacle’ dropped by more than half, strongly suggesting that women viewed the application process as less onerous than in earlier years.

More than half of women who applied for pregnancy-related OHP in the county where the clinic is located waited longer than state policy mandates, compared to 37 per cent across the total sample. The systems in place for processing pregnancy-related OHP applications in this county seemed to be in need of serious review and overhaul. The irony that women who lived closest to the clinic might wait longer for OHP than a woman coming from two, three or even five hours away, reveals the complexities of abortion access, in which delay factors and obstacles overlap, intersect and sometimes surprise.

This study confirmed the earlier finding that social support helps women overcome obstacles (Ostrach and Cheyney 2014). While this might appear obvious to those who work with vulnerable populations in health-care settings, there continues to be a gap in the literature on the role that social support plays in women’s ability to overcome obstacles to abortion. A sizeable percentage of women who reported that obstacles were ‘difficult to overcome’ also reported not perceiving adequate social support, and nearly half of all survey respondents reported that social support helped them overcome obstacles. The degree to which
strong social support networks may partially compensate for, or buffer women from some of the effects of, socioeconomic inequality, should be taken into account by those who work to safeguard women’s reproductive health.

Despite apparent improvements in the OHP application process, there is more to be done. With many women still waiting longer than state policy mandates for coverage, the lived experiences of low-income pregnant women who were delayed while applying for OHP must be taken seriously. One of the key risk factors associated with needing a second-trimester abortion in the United States is Medicaid eligibility (Jones and Weitz 2009) – women in poverty are far more likely to arrive at abortion clinics in later gestations of pregnancy (Kiley et al. 2010). This apparent catch-22, in which poor women who need Medicaid coverage to obtain an abortion are delayed from seeking care while they apply for Medicaid, and then are more likely to need second-trimester abortion care, for which they are already at higher risk, creates a perfect storm of abortion obstacles for these women – and makes efforts to improve the Medicaid application process, and the need to enforce such improvements, all the more relevant and necessary.

Medicaid delays can also impact health-care choices for women who might prefer an alternate method for early abortion. Clinic staff told of patients for whom a delay in the OHP application process denied them the option of a medication abortion instead of a surgical procedure. This health-care-related discrimination, in which the medical choices of people in poverty were constrained by bureaucratic delays, signified a particularly insidious and intractable form of structural inequality, alongside other disparities documented in low-income women’s difficulties accessing abortion. Poverty should not determine who has access to quality reproductive health care, or how long patients must wait for it – but in a setting where Medicaid was constrained by bureaucratic delays, signified a particularly insidious and intractable form of structural inequality, alongside other disparities documented in low-income women’s difficulties accessing abortion. Poverty should not determine who has access to quality reproductive health care, or how long patients must wait for it – but in a setting where Medicaid was constrained by bureaucratic delays. However, the fact that clinic directors and managers perceived OHP patients as being a drain on the clinic’s bottom line is a serious problem that needs to be carefully evaluated and addressed, particularly in light of the ongoing shortage of both Medicaid and abortion providers (Aksel et al. 2013; Hill 2012). Obviously, to ensure all women’s access to basic reproductive health care without endangering the continued presence of abortion providers, one solution to consider is legislative advocacy mandating adequate Medicaid reimbursements to cover providers’ minimum actual staffing and supplies costs, not reducing the number of patients covered by OHP. Failing that, the already limited number of second trimester providers have no incentive to offer the more expensive, more complicated and more time-consuming later care, further burdening the women most at risk for needing such care with greater travel challenges.

This study was designed as a follow-up to measure the impact of a policy change; this limited the scope of the research primarily to what had been explored in the earlier study. Moreover, due to IRB constraints and timing, the ratio of quantitative data to qualitative data is less balanced than would have been ideal, some findings are available only as descriptive statistics, without fully fledged narratives to contextualise
the Affordable Care Act (ACA) and how
author’s contacts, women were told this was due to
Medicaid eligibility confirmation. According to the
28 year 2014, they were waiting up to
navigating the OHP application process (numbering
women who contact the referral hotline for advice on
organisation staff and volunteers, low-income pregnant
development. According to accounts from grassroots or-
as already complete, to inform her of this new de-
for Medicaid (Network for Reproductive Op-
acted it beginning in early 2014, actually
accepted income thresholds to enrol more Oregoni-
s in OHP, in fact suspended existing policies to ex-
pedite pregnancy-related and other urgent Medicaid
applications had been suspended, they were informed that Oregon’s systematic roll-out
of the ACA, and the resulting way the state expanded
acceptable income thresholds to enrol more Oregoni-
s in OHP, in fact suspended existing policies to ex-
pedite pregnancy-related and other urgent Medicaid
applications (NRO 2014). In the first part of 2014, low-
income pregnant women in Oregon had to apply first
to the state health-care exchange to determine their el-
igibility for an ACA subsidy before they could apply
for pregnancy-related Medicaid, even if they knew
their income and poverty levels plus a current preg-
nancy made them undoubtedly eligible for Medicaid
rather than private-paid coverage (NRO 2014).
As the author quickly learned, when abortion hot-
line directors contacted DHS and other providers to
determine why the directive to expedite pregnancy-
related Medicaid applications had been suspended,
more troubling is the unsolicited new revelation
from a grassroots abortion referral and funding hotline
a member of the U.S.-based National Network of
Abortion Funds), based in the county where the study
was carried out, that provisions of the Affordable Care
Act (ACA) and the way Oregon policymakers imple-
ment it beginning in early 2014, actually suspended
the policy of expediting pregnancy-related applica-
tions for Medicaid (Network for Reproductive Op-
tions 2014). This apparently rolled back the clock on
progress made with the 2011 policy change. The
director of an abortion referral and funding hotline
that has long counselled women about how to apply
for Medicaid for an abortion contacted the author
after formal data collection for this follow-up study
was already complete, to inform her of this new de-
velopment. According to accounts from grassroots or-
anisation staff and volunteers, low-income pregnant
women who contact the referral hotline for advice on
navigating the OHP application process (numbering
in the thousands each year) reported that, as of Janu-
ary 2014, they were waiting up to five or six weeks
for Medicaid eligibility confirmation. According to the
author’s contacts, women were told this was due to
provisions of the Affordable Care Act (ACA) and how
it was being implemented in Oregon (NRO 2014).

It is worth noting that the ACA was itself a com-
promise of sorts, between a presidential administra-
tion that insisted on a goal of establishing a universal
health coverage mandate for all Americans, in the face
of anti-social welfare factions that refused to accept a
more typical national health system model. The result-
ing framework is based more on a market model, with
consumers choosing their mandated coverage from
within several options in the private market that have
adapted to a set of requirements federally established.
This alternative to the sort of health system seen in the
United Kingdom, Spain or other Westernised coun-
tries that do provide some level of universal health
coverage (Ostrach 2012) has obvious limitations, not
least in terms of delays in eligibility, coverage and ac-
cess. The author does not argue that the core concept
of universal health care is the problem, but rather that
the compromise ACA plan, falling far short of single-
payer, truly universal care, presents a myriad of access
issues, thus failing fully to address health disparities.

As the author quickly learned, when abortion hot-
line directors contacted DHS and other providers to
determine why the directive to expedite pregnancy-
related Medicaid applications had been suspended,
they were informed that Oregon’s systematic roll-out
of the ACA, and the resulting way the state expanded
acceptable income thresholds to enrol more Oregoni-
s in OHP, in fact suspended existing policies to ex-
pedite pregnancy-related and other urgent Medicaid
applications (NRO 2014). In the first part of 2014, low-
income pregnant women in Oregon had to apply first
to the state health-care exchange to determine their el-
igibility for an ACA subsidy before they could apply
for pregnancy-related Medicaid, even if they knew
their income and poverty levels plus a current preg-
nancy made them undoubtedly eligible for Medicaid
rather than private-paid coverage (NRO 2014).
Readers who follow health policy changes in the
United States may be aware of the ACA’s persistently
troubling patchwork of waiting times for this type of
enrolment and subsidy eligibility determination. Un-
like many European health systems, the ACA-man-
dated universal coverage requirement is predicated
upon Americans needing to apply for a state-level
subsidy, and then buying their own private health in-
surance coverage and attempting to apply the sub-
сидy, if eligible, to the out-of-pocket monthly or
annual premium costs, if they do not qualify for Med-
icaid), and the extreme unreliability of state and fed-
eral government online enrolment systems so far. The
processes of needing to apply for a subsidy, and then
buying private coverage or applying for reduced-cost
coverage, seem to have further affected Oregon
women navigating the ACA process as a first step to obtaining Medicaid coverage for either abortion or prenatal care (NRO 2014).

This bureaucratic, hopefully unintended, consequence of the ACA roll-out, something ostensibly meant to get health care to a larger number of the neediest Oregonians, instead may have exacerbated existing institutional delays and barriers to reproductive health care for the poorest women, based on anecdotal reports from the community-based abortion referral hotline that regularly coordinates communication between the author and Oregon clinics. While the policy change resulting from research-based advocacy that is the subject of this article briefly improved access to timely abortion care for low-income women, more recent developments since the follow-up date were collected appear to suggest that Oregon’s implementation of the ACA not only perpetuated but in fact may worsen health-care coverage delays and other disparities, obscured in a larger reformist attempt to reduce health disparities. Generalisations and assumptions about the link between state or national health systems, and waiting times for care, is the faithful sidekick to all discussions of health reform and universal coverage, in U.S. popular discourse. Unfortunately, in the case of Medicaid coverage for poor pregnant women in Oregon, now required to jump through ACA hoops, these stereotypes seem all too possibly founded.

Several years out from a 2011 policy change intended to streamline and expedite Medicaid coverage for low-income pregnant women, designed in part to shorten abortion delays and reduce obstacles to care, the advocacy efforts that resulted in that policy change have become all but irrelevant, at least for now. Apparently, Oregon’s health-care coverage for low-income pregnant women is once again at the mercy of unpredictable bureaucratic processes. This offers applied medical anthropologists whose research and advocacy focuses on health policy and health-care access an important lesson about the limits of systems-correcting praxis: even a good policy change can be abandoned. Even a very well-intentioned effort to expand poor Americans’ access to health coverage can have unintended consequences, delaying access to prenatal and abortion care for some of the poorest and most vulnerable. Applied research and advocacy are not enough, without vigilant, continued monitoring and enforcement, and corresponding macro-level adjustment, reform or challenge.

At the time the author analysed these data on the effects of the 2011 policy change, the findings were shared with the above-mentioned grassroots abortion and referral organisation, and with the legislator who facilitated the policy change. (The clinic where both studies were carried out had closed in early 2013, in part due to difficulty generating enough revenue to cover operating expenses, thanks to the combination of lower rates of cash-paying patients and competition from a large corporate reproductive health provider that opened nearby.)

The board members of the grassroots organisation planned to use the findings presented here to hold DHS accountable to continue improving waiting times for pregnancy-related Medicaid applications. Specifically, volunteers and leaders of the organisation who had become particularly concerned about the greater delays in the large county where the clinic was located, hoped to use the findings about those greater delays to pressure the local DHS offices to curtail reportedly biased treatment towards Medicaid applicants who mentioned an intent to seek an abortion, on the part of anti-abortion eligibility workers. Unfortunately, before the grassroots organisation could make much headway, using these findings, the implementation of the ACA, through Oregon’s particular system for the roll-out, worsened the problem of Medicaid delays for pregnant women in poverty. The work of expediting and facilitating low-income Oregon women’s access to both abortion and prenatal care, is far from over.

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References


Ostrach, B. and M. Cheyney (2014), ‘Navigating Obstacles: Women’s Experiences of Seeking Abortion Care in Oregon’, Qualitative Health Research 24, no. 7: 1006–1017. doi 1049732314540218