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Abortion Clinics and Contraceptive Services: Opportunities and Challenges

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Four decades ago, as health care providers, advocates and lawmakers fought for the legalization of abortion in the United States, the general expectation was that most abortions would be performed in hospitals. However, the intense political controversy over the procedure and continuing efforts by antiabortion activists to stigmatize and isolate abortion have led to most abortions being provided at specialized clinics. Today, that political isolation still poses serious problems in the forms of harassment of patients and providers, and targeted legal and regulatory restrictions. From a medical point of view, however, this reliance on specialist providers has worked out well. Abortion in the United States has an exemplary safety record and involves far less risk than carrying a pregnancy to term. Moreover, the way abortions are provided mirrors the rise of outpatient surgery and the preponderance of specialists, from cardiologists to podiatrists, throughout the U.S. health care system.

Yet, specialty care—for abortion or otherwise—does sometimes create difficulties for ensuring patients' access to all the care they need. One key example in the abortion context is patients' access to postabortion contraception. Having access to affordable and effective contraceptive services and supplies is especially important for women who have had abortions, because almost all of those abortions are the product of unintended pregnancies and because repeat unintended pregnancy is common: Forty-four percent of women having an unintended pregnancy have had at least one such pregnancy already.[1] Contraception, if practiced effectively, radically reduces the chance of an unintended pregnancy. Indeed, the two-thirds of U.S. women at risk of an unintended pregnancy who practice contraception consistently and correctly account for only 5% of unintended pregnancies.[2] New Guttmacher Institute research indicates that abortion providers are working to be part of a solution to this problem, by integrating contraceptive counseling and services into their standard practices, but that many of them—particularly specialized abortion services providers—see serious barriers to doing more.

Two Models for Abortion Provision

Specialized abortion clinics—defined as those in which at least half of their patient-visits each year are for abortion services—accounted for 21% of all abortion providers in 2008, but performed 70% of all abortions (see chart).[3] Almost all of the remaining abortions were provided at more comprehensive reproductive health centers, most of them affiliated with Planned Parenthood Federation of America (PPFA).

These two models for U.S. abortion provision have led to distinct differences in the contraceptive services provided to abortion patients. According to a 2009 Guttmacher Institute study that explored these differences and the barriers behind them by surveying a nationally representative sample of large, nonhospital abortion providers (which account for 91% of abortions each year), 96% of providers incorporate contraceptive education into abortion care.[4] This practice puts providers in line with the standards of major medical associations, including PPFA, the National Abortion Federation (NAF) and the

World Health Organization. The depth and format of this education varies considerably. Notably, specialized abortion providers are far more likely than comprehensive reproductive health centers to provide contraceptive education as part of a group, rather than one-on-one, although this practice is in neither case standard (22% vs. 5%).[4] Contraceptive education can be offered before an abortion, as part of the informed consent process, or afterwards, as part of immediate postabortion care or a follow-up visit.

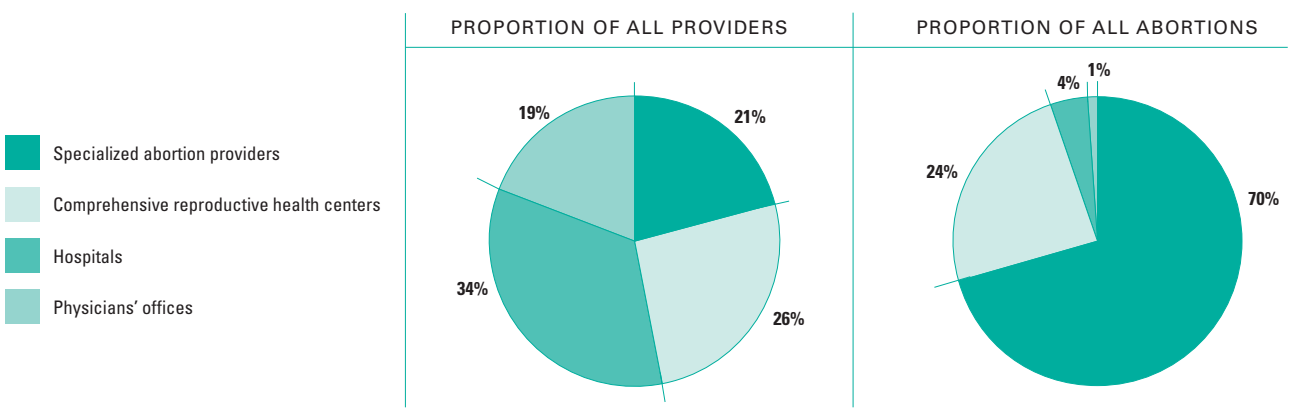
More substantial differences between the two models can be seen in terms of on-site contraceptive provision. Specialized abortion providers are considerably less likely than those with a broader focus to offer patients a full range of methods, including IUDs and implants—collectively known as long-acting reversible contraceptives (LARCs).[4] Rather, most specialized providers include whatever contraceptive services they offer in the cost of an abortion. That arrangement discourages the provision of LARCs and other methods with high up-front costs, and indeed, specialized providers are particularly likely to rely on one-time handouts of free samples of the pill, patch or ring. They are also less likely to have adopted several evidence-based strategies for improving contraceptive use: advance provision or prescription of emergency contraceptives, "quick-start" initiation of birth control pills at the clinic and immediate postabortion LARC insertion (see chart, page 4).

That comprehensive reproductive health centers are most likely to provide the broadest range of contraceptive services is not remotely surprising. With contraceptive services provision a core aspect of their mission, these providers have the expertise and infrastructure to provide patients—postabortion or otherwise—with a broad array of contraceptive choices, and the counseling and follow-up care needed to help them practice contraception most effectively. Some of these providers may, however, face complications stemming from restrictions on the use of Title X family planning funding. Under long-standing federal regulations, providers must keep activities under their Title X project "separate and distinguishable" from abortion-related services, a requirement that has resulted in administrative burdens such as maintaining separate patient charts. Separation has also limited the availability of some public funds and discounts for providing postabortion contraception, because some of those funds and discounts may only be used for patients in a health center's Title X project, which cannot include abortion (related article, Spring 2007, page 8).

Specialized abortion providers, by contrast, are not designed or seen as sources of comprehen-

ABORTION AS SPECIALTY CARE

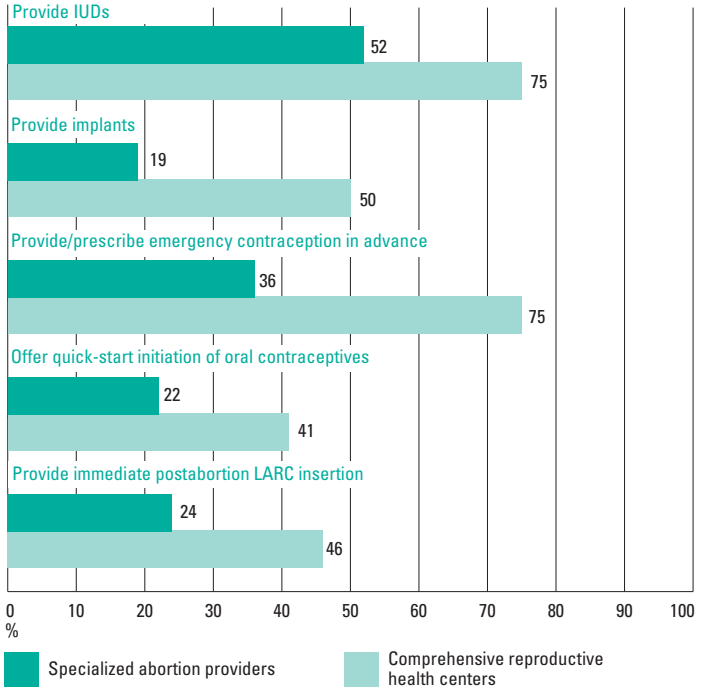
Specialized abortion providers accounted for one-fifth of the 1,800 U.S. abortion providers in 2008, but performed 70% of all abortion procedures that year.



Note: Specialized abortion providers are those having 50% or more of client visits for abortion services; comprehensive reproductive health centers have fewer than 50% of client visits for abortion services. *Source:* Reference 3.

THE PRICE OF SPECIALIZATION

Specialized abortion providers are less likely than abortion providers with a broader focus to provide a wide range of contraceptive methods and newer, evidence-based contraceptive protocols.



Source: Reference 4.

sive or ongoing care—whether for contraception or anything else. Abortion patients make up all or almost all of their caseload, and such patients often must travel long distances, a problem that has grown as the number of abortion providers has declined. Even local patients may be reluctant to make repeat visits: They may fear harassment from protesters or being recognized by neighbors, want to put an emotionally charged experience behind them or simply prefer to receive ongoing contraceptive services and other routine care from another type of provider.

Without a demand for ongoing care, specialized providers face financial and logistical hurdles to providing any effective and affordable contraceptive care. Insurance coverage is a prime example: According to Guttmacher's 2009 study, only 60% of specialized clinics accept either private insurance or Medicaid for abortion, and only 55% for contraception.[5] By comparison, 89% of comprehensive reproductive health centers that provide abortion accept some type of insurance for the procedure, and 94% do so for contraception.

It is understandable that many specialized providers do not devote the resources needed to navigate the complex world of third-party reimbursement. In most states, because of the long-standing federal restriction known as the Hyde amendment, Medicaid will pay for an abortion only in the most extreme circumstances. Private insurance coverage of abortion is more common, but even among women with private insurance, about two-thirds end up paying for an abortion out of pocket.[6] In some cases, that may be because the provider from which they obtain an abortion does not accept insurance; in others, a woman may not have or know she has abortion coverage, may have a high deductible she has not yet met or may wish to avoid using insurance out of confidentiality concerns.

Opportunities and Challenges Ahead

Ironically, many methods and practices most common at comprehensive reproductive health centers would be especially helpful to patients at specialized abortion providers. For patients traveling long distances and unlikely to return for follow-up care, providing a month or two of free pills is not of long-term value. Those patients would still need to visit a contraceptive provider back home; could experience gaps in use, which would leave them vulnerable to additional unintended pregnancies; and could end up switching to different brands or formulations, or different methods entirely, which can also be disruptive to effective use. Immediate postabortion LARC insertion, on the other hand, could provide patients with a long-term contraceptive solution.

Addressing this disconnect at specialized abortion providers between current practices and patient needs is not simple. In theory, a specialized provider could transform itself into a comprehensive reproductive health center. In practice, this would require a complete shift in the mission of the clinic and its staff, and involve numerous practical difficulties. In most cases, there would be no real need for this shift, because there are already family planning providers in the community. But even strength-

ening referral ties with these comprehensive providers to facilitate patients' access to postabortion contraception may be of limited utility, because of the distance many patients travel for abortion.

A potentially more promising option for specialized abortion providers would be a limited mission expansion: adding the provision of LARCs and even sterilization—both postabortion and even as independent services. From the perspective of specialized clinics, providing some or all of these services would be well within their potential expertise, because they are already set up to perform outpatient surgical services, although some additional staff training would be necessary. From a patient's perspective, LARC insertion and sterilization are infrequent or one-time events that do not necessitate an ongoing relationship with the provider. The frequency of postpartum sterilization in the United States is an encouraging sign that abortion, too, could be paired with long-term contraception. Yet, accomplishing even this limited transformation would mean overcoming barriers. Three major clusters of barriers, each cited by about eight in 10 abortion providers, center on demand, costs and reimbursement.[5]

Demand Barriers

In another new Guttmacher Institute study, one-third of abortion patients surveyed expressed interest in using LARCs.[7] Nevertheless, adding new information and options for postabortion contraception is a challenge to many abortion providers, who see their patients as anxious and already overwhelmed with information about the immediate procedure. Moreover, although U.S. demand for sterilization is strong, and demand for IUDs and implants is growing rapidly,[8] American women have limited expectations for the services they can and want to receive at specialized abortion clinics.

Changing those expectations could require an investment in marketing—a thoroughly ingrained practice for most American businesses, but not necessarily for specialized abortion clinics, which may not invest in marketing because their operating capital is limited and because they may prefer a low profile to avoid harassment and threats. It could also require changes to how abortion clinics time and structure the contraceptive information and counseling they provide to patients. Common sense says that few patients will be receptive to the option of postabortion LARC if it is first broached hours before the abortion or if the offer is perceived as paternalistic. Clinics would also need to address basic logistical issues, such as the 30-day waiting period required for Medicaid-funded sterilization, a requirement that makes immediate postabortion sterilization impractical for Medicaid patients (although not for sterilization provided independently of an abortion).

Finally, specialized clinics would need to confront issues of demand for follow-up care. Although abortion providers offer follow-up care to their patients, it is in most cases not medically required, and many patients do not return for follow up. Provision of LARC or sterilization may change that situation by adding to the types of questions and concerns that patients have. Some of those questions can be addressed by phone, and for patients traveling long distances, an abortion provider may facilitate in-person follow-up care at a more convenient facility.

Cost Barriers

A second core challenge is the high up-front cost of long-term contraception, despite the long-term cost-effectiveness of these methods. Abortion is increasingly concentrated among low-income women,[6] and few abortion patients could afford hundreds of dollars out-of-pocket for an additional surgical procedure and the IUD or implant device. Specialized clinics, too, may have difficulty fronting the cost of keeping LARCs on the shelf, particularly if demand is uncertain. And these cost issues are growing: The list price of Mirena, the hormonal IUD, doubled in 2010, and the manufacturer of the copper IUD, ParaGard, has announced a substantial price increase in 2011.

One of the traditional checks on costs for prescription drugs and devices—the availability of generics—does not currently exist for IUDs and implants in the United States, although numerous brand-name and generic varieties are sold

worldwide. As the U.S. market for LARCs grows, this situation may change, but obtaining approval from the Food and Drug Administration can take many years, in part because a long-term method must be proven effective for U.S. women over the entire life of the product.

Manufacturers do offer patient assistance programs, which provide free devices to some low-income patients, but logistical issues, such as the need for advance approval, can limit their use. In addition, providers can sometimes negotiate discounts. However, Laura Galloway, director of clinical services at NAF, notes that a group like NAF is in a Catch-22 situation: To negotiate a deep discount, it would need to demonstrate substantial demand among its members, something it cannot do at current prices.[9]

Reimbursement Barriers

The most obvious solution to cost barriers is health insurance, both public and private. The Affordable Care Act (ACA)—the health reform legislation passed by Congress in 2010—is designed to expand the number of Americans with Medicaid and private insurance. If implemented as planned—and if antiabortion forces do not succeed in driving out private insurance coverage of abortion (related article, Fall 2010, page 2)—the ACA should provide new incentives for specialized abortion providers to accept insurance, as increasing numbers of their clients become insured.

For a clinic that does not yet accept insurance, that step is a large one to take. The U.S. insurance system encompasses a vast array of payers, including state-run fee-for-service Medicaid programs, Medicaid managed care plans, private insurance plans and self-insured employers. In theory, each payer may have different and constantly changing reimbursement rates and procedures.

Postabortion contraception adds additional layers of complexity. Reimbursement for these services and supplies depends in part on the contracts a clinic negotiates with insurers, public or private. Some contracts may set a bundled abortion reimbursement rate that includes contraceptive care, an arrangement that discourages providing high-cost methods. Instead, clinics looking to provide LARCs and sterilization would want to seek separate reimbursement.

There are two major components to that reimbursement: the supplies (such as an IUD or implant) and the services (including the procedure itself and any necessary counseling, screening and follow-up). Most public and private insurance plans will reimburse fully for the supplies, but there can be complications. For example, insurers' reimbursement rates may not quickly adjust to rising prices, and some insurers may cover an IUD or implant under their pharmacy benefit, which may force the patient to purchase the device ahead of time at a pharmacy.

Reimbursement for a medical or surgical procedure typically includes any follow-up care by the same provider within a set timeframe afterwards (e.g., 10 or 90 days, depending on the complexity of the procedure). For a separate procedure on the same day or during that follow-up period—such as LARC insertion or sterilization after an abortion—a provider, in theory, will submit a claim with the secondary procedure tagged with a special "modifier" to the standard billing code, and insurers will typically provide reduced reimbursement for that secondary procedure. In practice, variation in and confusion about insurers' reimbursement procedures, as well as sometimes low reimbursement, can be barriers for clinics.

In addition, some plans may require preauthorization for higher-cost contraceptive methods—a concern cited by more than half of abortion providers in the 2009 study[5]—or place other restrictions on their coverage. Patients may avoid using their insurance coverage out of confidentiality concerns, as many do for the abortion procedure itself, or may require the provider's assistance to learn what their plan will cover. According to Paula Bednarek, an assistant professor in the Department of Obstetrics and Gynecology at the Oregon Health and Science University, specialized abortion providers may face hurdles with some insurers in being designated as a family planning provider and contracting for family planning services, in part because the pool of potential family planning providers is

far larger than the pool for abortion, and insurers, therefore, are likely to have an adequate network already for family planning.[10]

Medicaid can add additional complexity. Notably, in states that do not pay for abortions under Medicaid, abortion providers may face red tape, confusion or political concerns about seeking Medicaid reimbursement for the contraceptive services they provide, even though such reimbursement can be sought legally under the Hyde amendment. On the other hand, Medicaid could also help solve some of these reimbursement problems. State Medicaid officials could take steps to encourage plans to fairly reimburse for postabortion contraception—for example, by designating specific billing codes for postabortion contraceptive procedures or by sending letters to Medicaid managed care plans or providers signaling their support for the practice and spelling out appropriate billing practices. And because private insurers often follow Medicaid's lead, the impact of such steps could be felt more broadly.

Embracing Change—and Risk

Clearly, the U.S. health insurance system is challenging to navigate. The fact is that most health care providers do manage it, but it requires substantial training, investment and staff time. "It really requires an army of billing people to make sure you're getting reimbursed for what you're supposed to be," says Eve Espey, a professor and obstetrician-gynecologist at the University of New Mexico.[11] And because the rules keep shifting and insurers provide little transparency, "most of the time, you just have to bill them and see what happens."

Investment—financially and institutionally—may be the most critical ingredient needed for specialized providers to embrace the opportunity presented by LARCs and sterilization. In that sense, it is no different than the challenges faced by all safety-net providers in the evolving U.S. health care system. New arrangements for coordinating care, the emergence of electronic medical records, ever-advancing medical science and standards, increasing pressures to scale back costs and improve quality—all of these trends pose opportunities and challenges that demand providers' investment.

Embracing these changes also involves embracing risk. Will we be able to find capable staff, train them well and be able to retain them? Will we be able to draw in enough new clients? Will we be able to avoid being cheated by insurers? Will we lose our sense of mission? These questions, and countless others, are ones that providers must ask but cannot be sure of the answer.

Nevertheless, virtually all abortion providers already assert that providing postabortion contraception is a priority for them.[5] Specialized abortion providers face real opportunities to do more on that front by expanding their mission to include services for long-acting and permanent contraception. Doing so could have real payoffs for women, families and society in the form of fewer unintended pregnancies. **www.guttmacher.org**

REFERENCES

1. Jones RK, Singh S and Finer LB, Repeat Abortion in the United States, *Occasional Report*, New York: Guttmacher Institute, 2006, No. 29.

2. Gold RB et al., *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System,* New York: Guttmacher Institute, 2009.

3. Jones RK and Kooistra K, Abortion incidence and access to services in the United States, 2008, *Perspectives on Sexual and Reproductive Health,* 2011, 43(1):41–50.

4. Kavanaugh ML, Jones RK and Finer LB, How commonly do U.S. abortion clinics offer contraceptive services? *Contraception,* 2010, 82(4):331–336.

5. Kavanaugh ML, Jones RK and Finer LB, Perceived and insurance-related barriers to the provision of contraceptive services in U.S. abortion care settings, *Women's Health Issues,* 2011, doi:10.1016/j.whi.2011.01.009.

6. Jones RK, Finer LB and Singh S, *Characteristics of U.S. Abortion Patients*, 2008, New York: Guttmacher Institute, 2010.

7. Kavanaugh ML, Carlin EE and Jones RK, Patients' attitudes and experiences related to receiving contraception during abortion care, *Contraception*, 2011, doi:10.1016/j.contraception.2011.03.009.

8. Mosher WD and Jones J, Use of contraception in the United States: 1982–2008, *Vital and Health Statistics,* 2010, Series 23, No. 29.

9. Galloway L, NAF, Washington, DC, personal communication, Apr. 6, 2011.

10. Bednarek P, Oregon Health and Science University, Portland, OR, personal communication, Apr. 25, 2011.

11. Espey E, University of New Mexico, Albuquerque, NM, personal communication, Apr. 7, 2011.