

Reproductive Justice Advocacy from the Ground Up

A Policy Agenda for Underserved Women, Their Families and Communities

Introduction

ACCESS/Women's Health Rights Coalition (ACCESS) removes barriers to sexual and reproductive health care experienced by California women and girls, and builds their power to demand health, justice and dignity. We believe in a future where women's voices are clear and strong; where each woman trusts herself, knows her own value and is confident in her connection to the world around her. We believe in a future where women decide for themselves whether, when and how to have children. A future where women have access to the options they need to realize their decisions.

We are committed to effecting policy change in the health care and social services systems that serve to broadly improve women's health, safety, and economic autonomy. Our ultimate goal is to become obsolete, by building the power of California women to create social change and influence the administrative and legislative policies that shape it so that all women have the social, political, and economic power and resources to make healthy decisions about their gender, bodies, and sexuality for themselves and their families.

With sixteen years of experience eliminating obstacles to quality reproductive health care in partnership with low-income women of color, ACCESS is particularly well-positioned to inform policy debates about reproductive health. Our bilingual Reproductive Healthline provides free, confidential and nonjudgmental information, referrals, peer counseling, funding, practical support and advocacy on the full range of reproductive health services including pregnancy, parenting, abortion, and adoption. We also connect women with public

insurance programs that pay for this care, such as Family PACT, Medi-Cal and AIM. ACCESS has worked with well over 20,000 California women seeking all types of reproductive health care since its inception, giving us a breadth of personal narratives to shape our policy agenda.

Often, health care policy debates, both locally and nationally, fail to take into account the real life experiences of men, women and their families. Yet, it is these everyday experiences that illustrate the impact of new policies on access to care and health outcomes. ACCESS encounters the complex realities of our caller-partners' reproductive lives through our Healthline, translates those lived experiences into our priority policy campaigns, and actively engages and builds the power of low-income women of color as leaders for positive change in their communities. We know that simply enacting strong laws and policies is not enough to ensure that women's health care needs, and that of their families, are actually met. For example, even though California has some of the most progressive laws around reproductive health, women still face numerous barriers to reproductive health care because of, but not limited to: a lack of providers, insurance issues, travel expenses, misinformation and judgmental people.

The administrative and legislative policy recommendations that we offer in this agenda address systemic state and federal issues that directly impact California women seeking all types of health care, including reproductive health services like prenatal and abortion care. Using the stories of our caller-partners to contextualize the issues, we promote solutions that deal with access to the safety net; the

number of reproductive health care providers in the state who accept Medi-Cal; contribute to federal efforts to allow public funding for abortion; and, provide a practical reproductive health and justice perspective on health care reform debates in California and nationally.

Ensuring Access to the Safety Net for Pregnant Women

“Maria, 35, from Daly City is 14 weeks pregnant. She separated from her husband and has 2 children. She wants to terminate her pregnancy because she is already struggling financially to support her family. She called ACCESS for help because she applied for Medi-Cal at a local social service agency four weeks ago and has just been told that she only qualifies for share-of-cost Medi-Cal, and will have to pay a \$500 deductible for an abortion, which she doesn’t have. She heard from a co-worker who was also in her situation, that she was able to get Restricted Medi-Cal for Pregnancy in two days. Maria said that when she told her case worker about Medi-Cal for Pregnancy, the case worker had no idea what that was. The case worker proceeded to submit an application for full-scope Medi-Cal for her and told her it would take more than four weeks to process. When Maria objected that she would then be in her second trimester, the caseworker said she would just have to wait.”

The barriers facing low-income women are not exclusive to reproductive health care access, but are rather reflective of problems many Californians face when trying to access safety net programs, particularly Medi-Cal. Low-income communities and communities of color have the highest rates of disease and the poorest health outcomes, and the safety net is therefore critical to both the short-and long-term health outcomes of California residents. Those who are unable to access health care, whether they lack insurance or money to pay for services, are more likely to report delays in care.ⁱ Application for Medi-Cal sometimes exacerbates these delays. An evaluation found that 59% of Medi-Cal beneficiaries stated that the hours that Medi-Cal enrollment offices are open were not convenient

and 78% believed that signing up for Medi-Cal required too much paperwork.

Despite these barriers, thousands of California women still depend on Medi-Cal, and other safety net programs, for reproductive health care. California’s family planning program, Family PACT, plays a vital role in ensuring that men and women can prevent pregnancy, plan the number and spacing of children, or prevent sexually transmitted infections. In FY 2003-04, 1.61 million women ages 15-44 years were in need of publicly funded family planning servicesⁱⁱ. For every dollar spent on Family PACT, California saves more than \$2.76 after two years, and up to \$5.33 within 5 years, in the cost of services for unintended pregnancies.ⁱⁱⁱ

In 2005, Medi-Cal funded approximately 45% of all abortions in California, an estimated 94,602^{iv} induced abortions out of the total 208,430 performed.^v While a vital resource to pay for all types of health care, Medi-Cal remains an often inaccessible or inadequate source of care for low-income women seeking reproductive health services in California. Most uninsured women qualify for Medi-Cal but encounter cumbersome eligibility application processes, rampant misinformation about standard application requirements, frequent case process delays and, more recently, onerous identity documentation requirements adopted as a result of the Federal Deficit Reduction Act of 2005.

For pregnant women seeking abortion or prenatal services, delays in accessing coverage can cause them to receive care at later gestational ages of pregnancy, resulting in insufficient prenatal care and riskier, costlier terminations. Pregnancy programs, which cover pregnancy-related services and help women get early prenatal care, including Presumptive Eligibility, Restricted Pregnancy Medi-Cal and Access for Infants and Mothers, also save the state money by helping to prevent the costly treatment necessary for pre-term or low-weight births^{vi}.

The Presumptive Eligibility (PE) program encourages early prenatal care, and enables a

provider to “presume” a pregnant woman is eligible for Medi-Cal based on her answers to a few income and residency questions. Therefore, a pregnant woman can receive medical care at a qualifying doctor’s office or clinic with the agreement that she will later apply for regular Medi-Cal through a county social service agency in order to continue receiving coverage for her care. This program covers all walk-in prenatal care services except for delivery, family planning and certain optional abortion procedures.^{vii}

Thanks to recent administrative advocacy with the Department of Health Care Services (DHCS), many abortion services that were not covered under PE are now covered, and services that were covered but were not clearly articulated through billing codes have now been clarified. In fact, DHCS recently published a billing and policy update that details certain additional ultrasound codes that can now be billed for the treatment of spontaneous abortions and unspecified [therapeutic] abortions.^{viii} Yet, interviews conducted with several reproductive health care providers throughout the state indicate that many providers do not know about or are still unable to bill for these services and are, therefore, not able to offer patients with PE the same level of care that they offer other patients.

While the PE program endeavored to provide pregnant women with the resources to obtain early prenatal care, it has also become an important resource for women terminating a pregnancy. Simultaneously, it is increasingly difficult for women to apply for and receive Medi-Cal. The quick processing of PE and direct connection to providers allows patients to make timely and informed decisions about their pregnancies, and receive care faster. For patients seeking abortion care through PE, timely processing ensures that patients can access earlier, safer and less expensive abortion procedures.

The current fiscal climate in California only serves to exacerbate concerns with the access to care and safety net eligibility. Soaring

unemployment rates are forcing many more Californians into the safety net system, and vital reproductive health programs. Yet these programs have already suffered, and are likely to experience more cuts and restrictions this budget season, which will eliminate necessary benefits for over 3 million existing enrollees and effectively deny or eliminate coverage all together for hundreds of thousands of previously eligible Californians.^{ix} Poor communities of color are, unsurprisingly, among the hardest hit.

Policy Recommendations

California cannot afford to deny low-income women health care coverage for pregnancy, abortion or other reproductive care because of persistent institutional errors, billing inaccuracies and continuing cuts to programs.

1. Improve policies and implementation at county social service offices that administer Medi-Cal and other safety net programs.
 - a. Facilitate the provision of clear information to applicants about policies for pregnancy services through eligibility workers and other frontline staff;
 - b. Enforce existing eligibility policies, and hold eligibility workers accountable for their proper implementation;
 - c. Ensure timely processing of applications for pregnancy-related care;
 - d. Create a brochure with information about the Restricted Pregnancy Medi-Cal program; and,
 - e. Ensure that all applicants feel welcome and safe when applying for benefits.
2. Improve communication and implementation between the Department of Health Care Services, safety net beneficiaries and reproductive health care providers.
 - a. Include explicit information about pregnancy-related services in all publications and correspondence;
 - b. Standardize the terminology used to access Medi-Cal programs and clarify for patients, advocates and social service staff what terminology applicants should use when requesting Restricted Pregnancy services;

- c. Clarify and promote the abortion-related services covered under PE; and,
 - d. Ensure timely PE reimbursements and clear guidelines about billing for abortion services.
3. Reject current and future cuts to Medi-Cal and other safety net programs, and find alternatives to fund these vital services.

Expanding the Pool of Medi-Cal Providers for Reproductive Health Care, Including Abortion

“Jackie, 16, called from Corning for help with transportation. She is 17 weeks pregnant and was turned away from the closest abortion provider to her in Chico, about 45 minutes away, because she is too far along for them to see her. She began searching for abortion care when she found out she was pregnant at 10 weeks, but after several missed appointments at the Chico clinic because of transportation issues, she now has to travel to Sacramento. Sacramento is 115 miles away, more than two hours, and she will have to stay in Sacramento overnight for the two day procedure.”

Finding doctors and specialists who accept Medi-Cal is becoming increasingly difficult in California as fewer and fewer providers choose to contract to see Medi-Cal patients. Forty-one percent of California counties do not have an abortion provider, including Tehama County, where Jackie lived. Similar to national trends, the number of total abortion providers in California has recently declined. In 2000, California had 400 abortion providers, which represented a 19% decrease since 1996. ACCESS research indicates that there are currently only 189 publicly

advertised providers in California, and the numbers continue to decline. Not surprisingly, in an evaluation of Medi-Cal, 56% of beneficiaries cited that once enrolled in Medi-Cal, locating a Medi-Cal provider was somewhat or very difficult.^x Even for those women able to transcend barriers to coverage, it is increasingly difficult to find local reproductive health care providers, and particularly abortion providers, who will accept Medi-Cal to cover the cost of care.

The shortage of abortion providers results from a steady decrease in the numbers of physicians who are trained to perform abortion, fear of intimidation, harassment and violence, and, in California specifically, persistent provider problems with fair and timely reimbursements for Medi-Cal services. There has been a steady decrease in the number of OB/GYN residency programs that offer abortion training and the population of providers who are still practicing are “graying.” In fact, sixty-three percent of all OB/GYNs who perform abortions are aged 50 and older.^{xi}

Often, California providers cannot afford to treat Medi-Cal patients because of severely low reimbursement rates and the time-consuming process for submitting claims. A survey of abortion providers who perform procedures through 24 weeks but no longer accept Medi-Cal revealed that reimbursement rates for second trimester abortions are too low to cover the expenses associated with procedure. As noted in the table below, private insurers reimburse for the same procedures at a rate almost double that of Medi-Cal after 20 weeks gestation.^{xii}

Medi-Cal Reimbursement by Gestational Age

Weeks Gestation	12.1-14.0	14.1-16.0	16.1-18.0	18.1-20.0	20.1-22.0	22.1-24.0
Medi-Cal Reimbursement for All Services ^{xiii}	474-575	474-575	474-575	474-575	474-575	474-575
Medi-Cal Reimbursement for Procedure only	253-265	253-265	253-265	253-265	253-265	253-265
Private Reimbursement ^{xiv}	400-714	475-714	600-925	650-925	900-1788	1250-1900

The Medi-Cal reimbursement rates reflected in the table on page 4 also do not take into account the difference between early and later second trimester procedures. The reimbursement rate for the D&E procedure (CPT 59841) is the same for a procedure performed at 15 weeks or 24 weeks gestation. However, as gestation progresses, the procedure is likely to be more complicated and time-consuming, and thus more costly to the clinic or hospital. Because of the high demand at 24 weeks, providers often postpone the procedures of women who seek care at 20 weeks – unnecessarily increasing the risk, time and cost to the provider and, ultimately, to Medi-Cal. If current Medi-Cal reimbursement rates were increased to adequately cover the cost of second trimester abortions, providers who perform these procedures but do not currently accept Medi-Cal might change their policies to begin or resume accepting Medi-Cal.

Policy Recommendations

1. Increase Medi-Cal reimbursement rates for procedures and services related to abortion.
2. Reform the process of submitting, evaluating and processing Medi-Cal claims for terminations:
 - a. Allow claims for second-trimester abortion services to be submitted electronically;
 - b. Train staff and auditors to understand abortion practice and to properly review medical evidence submitted on behalf of claims;
 - c. Appoint an ombudsman to oversee the processing of abortion claims, particularly second trimester abortion claims; and,
 - d. Ensure that the processing of Medi-Cal claims and issuance of reimbursements happens within a mutually agreed upon and reasonable timeframe after submission.
3. Fund and support initiatives, such as the Primary Care Initiative (PCI), to reintegrate

early abortion provision into women’s primary health care:

- a. Create policies allowing a broad range of advanced practice clinicians, such as nurse practitioners, certified nurse midwives and physician assistants, to provide first trimester aspiration abortion as a component of primary health care.
4. Create incentives like federal and state funded scholarships, tuition reimbursements and loan forgiveness programs for providers who choose to practice in rural or isolated areas after medical school graduation.

Guaranteeing Access to Comprehensive Reproductive Health Care for Low-income Women

“Janice, 19, called from a military base in San Bernardino. She is about to start training, but found out that she is pregnant. She is not ready to be a mother and would like to terminate her pregnancy, but does not have money to pay for the procedure and she just found out that her insurance plan does not cover abortion. Her commander is pressuring her to ‘take care of the pregnancy’ before training starts, so she has to come up with \$500 by next week and has no one to turn to.”

Stories like Janice’s abound in California and across the country. In 1976, Congress passed the Hyde Amendment, which prohibits the use of federal funds for abortion services, except in cases where carrying the pregnancy to term might jeopardize the woman’s life. In California, and 17 other states,^{xv} our Medi-Cal and PE programs cover abortion care for any reason for qualified women. However, there are many women in California who, because of the source of their health coverage, are denied abortion services under the Hyde Amendment. Like Janice, women in the military, disabled women on Medicare, women in the Peace Corps, women in federal prisons, women who

are federal employees and others who are dependent on federally-funded health insurance, do not have abortion coverage and face drastic delays in care.

Policy Recommendations

1. Ensure that California women impacted by Hyde have access to affordable abortion care:
 - a. Educate women about the availability of Medi-Cal for pregnancy when their insurance does not cover abortion; and,
 - b. Work with federally-funded insurance plans (i.e. Tri-Care, Champus, etc.) to negotiate the guidelines that providers must follow to bill the appropriate party for abortion care and publish these guidelines for the benefit of patients, advocates and social service agencies.
2. Ensure that California women impacted by Hyde have medically-accurate information about abortion care:
 - a. Insurers must require that providers disseminate accurate information about abortion, even if the insurer does not cover the procedure.
3. Congress and the President must take action to repeal the Hyde Amendment.

Shaping Health Care Policy and Services that Addresses the Unique Needs of Women and Girls

The current attention on health care reform at the state and federal levels offers an important opportunity to transform public and private systems, making them more responsive to the needs and experiences of women and their families. Comprehensive health care must promote the health and well being of low-income women, their families and their communities in order to eliminate the significant health disparities that exist in the United States. Furthermore, the standard of care and benefits adopted must include access to comprehensive reproductive health care, including abortion. Strong data shows that

reproductive health is a key factor in women's overall health. Programs and services that promote reproductive health, and reflect the lived experiences of women accessing care, should, therefore, be at the forefront of any federal or state health care legislation.

Women and girls face unique health care challenges, which are imperative to consider and remedy in state and federal health care reform debates. The number of women and girls who are uninsured is increasing and the skyrocketing cost of health care has erected insurmountable barriers to accessing care for both insured and uninsured women. Women are less likely to be insured through employers and more likely to be covered as dependents^{xvi}. At the same time, women live longer, are more likely to have chronic health problems^{xvii} and use more health care services over the course of their lives than men. All of this translates into poorer health outcomes for women and girls and illustrates the need for health care reform policies to not only include gender specific services, but also to create standards of care that champion the health of women and girls.

Young women and women of color face disproportionate barriers to comprehensive health care, leading to poorer health outcomes when compared to their counterparts. The number of uninsured, low-income women of color is much higher than the rates for other women. This is particularly alarming amongst Latinas, who have uninsured rates of approximately 39%^{xviii}. Young women of color also disproportionately depend on safety net programs like Medi-Cal and Family PACT. Initial data for 2007-2008 indicated that women aged 18-34 make up 74% of Family PACT clients.^{xix} Young women and women of color also disproportionately lack access to health care and are less likely than those with health insurance to seek preventive care services, which results in poor health outcomes and increased health care costs. Women of color (28.4%) are more likely than white women (12.5%) to report that they are in fair or poor health^{xx}.

Policy Recommendations

To address the health care challenges women face, health care reform must create accessible, affordable and comprehensive coverage.

California and Congress must make health care investments now that will enable girls to grow into healthy women. Health care reform, therefore, must:

1. Ensure access to affordable, accessible, high quality, comprehensive health care for all residents, independent of income, employment, gender, sexuality, ability, immigration, incarceration or health status;
2. Include comprehensive benefits, including comprehensive reproductive health care and abortion;
3. Guarantee women and girls access to care that is equitable and culturally and linguistically appropriate, with particular attention to vulnerable and underserved communities;
4. Provide health care coverage that is affordable for individuals and families in relation to income;
5. Guarantee that individuals and families have continual and timely access to health care;
6. Be fairly financed and establish mechanisms for controlling costs without impeding access;
7. Address community as well as individual health; and,
8. Include the public's input in shaping health care proposals.

We ask California specifically to:

1. Become a leader in national health care reform to ensure that the interests and voices of Californian's underserved are elevated in debates and negotiations.
2. Create a transparent and flexible system for implementation of health care policies that will allow public input and participation.

Conclusion

ACCESS strives to bring the experience and voices of our caller-partners to the attention of policymakers. Very often, ideas for new policies or reforms come from theoretical discussions, but the everyday application and practice of the policies is not considered. This proves especially true with issues affecting underserved communities, communities of color and women. We, therefore, advocate for policies that observe and honor the everyday experiences of the people most affected, and attempt to address both the root causes of social issues and the practical application of social and economic policies.

ACCESS can serve as a resource for policy makers seeking to advance a reproductive justice agenda, providing the voices, stories and expertise to ensure that all women have the social, political, and economic power and resources to make healthy decisions about their gender, bodies, and sexuality for themselves and their families. We hope that the policy recommendations we have outlined here will spark debate and foster policy that moves a reproductive justice agenda boldly forward. We welcome your support in this work and your continued championship of policies that promote the health and well-being of all women, their families and communities.

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Endnotes

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^{xii} ACCESS/Women's Health Rights Coalition. 2006 Survey of Second Trimester Abortion Providers in California; Planned Parenthood Affiliates of California. Private Sector vs. Medi-Cal Reimbursement.

^{xiii} Includes laboratory studies, routine ultrasound, laminaria for second trimester procedures, medication and supplies, pre-op and follow-up exam. Oral contraceptives and Plan B dispensed, but billed to either Family PACT or Medi-Cal.

^{xiv} Sampling of rates paid by private third party payers. These rates are generally bundled rates. Aspiration through late term abortion procedures include pregnancy testing and counseling, all customary medication, laboratory studies and supplies, pre-op exam, routine ultrasound, laminaria and laminaria insertion, physician charges, post-op visit, and 1 cycle of oral contraceptives. Rates vary by contracted gestational ranges.

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