THE UNDUE BURDEN OF PAYING FOR ABORTION: AN EXPLORATION OF ABORTION FUND CASES

DATA FROM THE NATIONAL NETWORK OF ABORTION FUNDS' GEORGE TILLER MEMORIAL ABORTION FUND, 2010-2015

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INTRODUCTION

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Less than eight hours after abortion provider Dr. George Tiller's assassination in 2009 by anti-abortion extremists—in response to a many inquiries, and the resulting request from Dr. Tiller's own office—the National Network of Abortion Funds created the George Tiller Memorial Abortion Fund, also referred to as the Tiller Fund.

The research presented in this report is comprised of secondary data analyses of 3,999 administrative cases in the U.S. showing how the Tiller Fund has been used over the five years from 2010 to 2015, including information about who was funded and what circumstances were at play in their lives when they needed abortion funding. Clients in the second trimester were prioritized by NNAF for funding assistance, given the increased costs and the need for expediency associated with abortions in the second trimester.

Sample demographics were examined and compared to demographics of abortion patients nationally.[1] Costs, funding assistance, patient resources, and changes over time in pledges for second-trimester procedures were also examined. The researchers also examine whether pledges for procedures in the second trimester increased over time in light of increases in state-level abortion restrictions enacted from 2010-2014. Further, the researchers traced geographic origin, and whether or not funding requests were more likely to originate from states with Medicaid and private insurance restrictions.

The report makes a case that paying for abortion is an undue burden on anyone who is seeking one. The results of this research suggest a need for repeal of discriminatory abortion policies and for abortion to be fully covered by all health insurance, both public and private.

The National Network of Abortion Funds (NNAF) and approximately 70 member organizations work to remove financial and logistical barriers to abortion access by centering people who have abortions and organizing at the intersections of racial, economic, and reproductive justice. The funding provided is a vital public health resource given the difficulties accessing abortion in the U.S., yet little was previously known about the impact of the assistance provided.[2,3,4]

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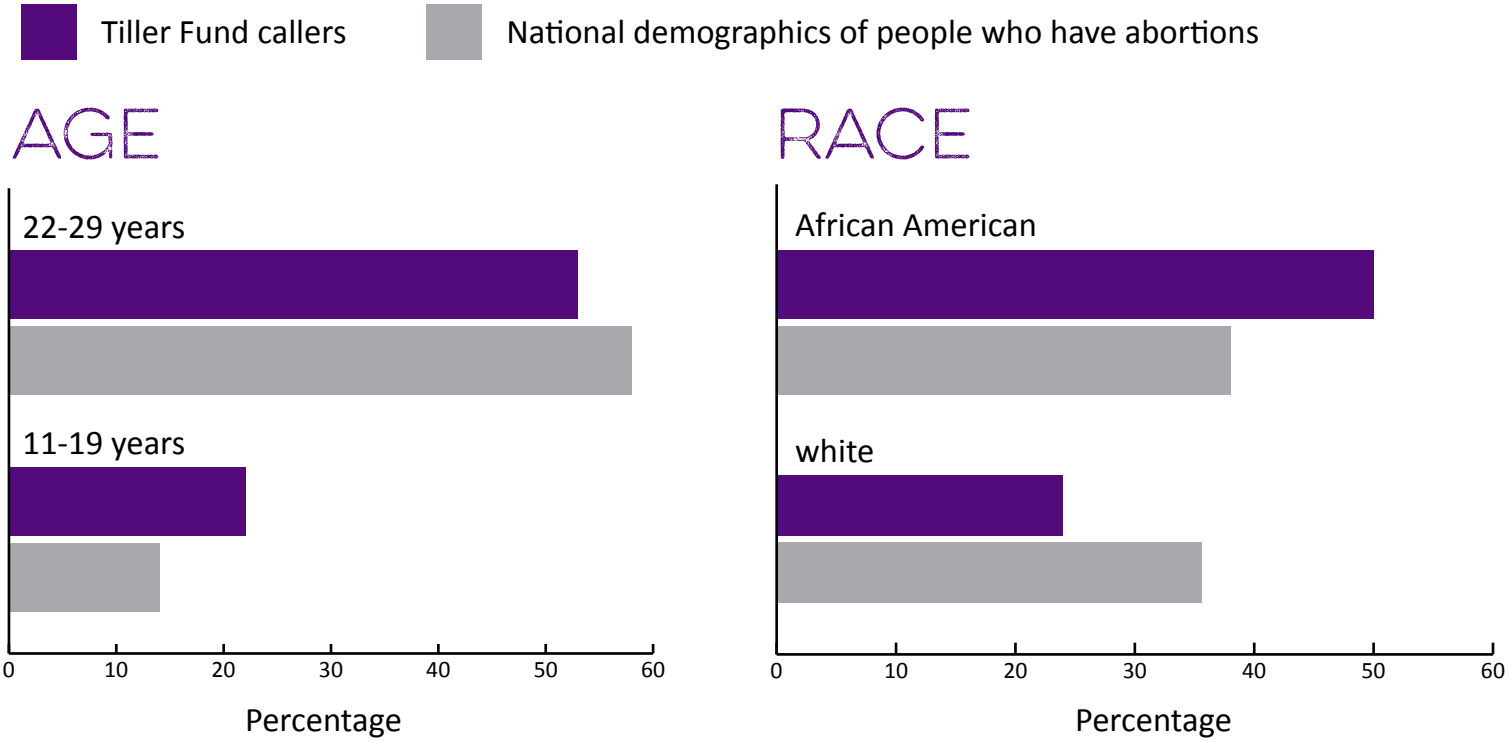
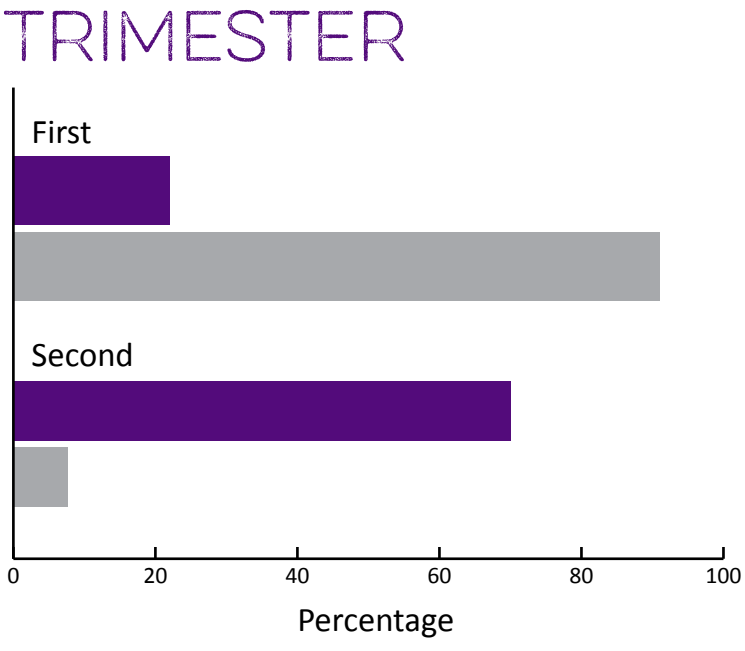
Front Cover Photograph: Women's Medical Fund, courtesy National Network of Abortion Funds, 2016.

WHO WAS FUNDED?

"Age was collected categorically in years, with the largest cluster (53%) falling within 20-29, slightly less than abortion patients nationally (58%). More patients (22%) were adolescents (11-19) relative to patients nationally (14%). In terms of race, the sample was **predominantly African American (50%)**, notably higher than patients nationally (38%). Fewer (24%) were white, considerably lower than patients nationally (37%). Ten percent were Latinx compared to a higher national average of 22%. In regards to gestational stage, compared to 91% of those in the national dataset only 22% of the current sample was in their first trimester."[2]



"The majority of the sample were in their second trimester (70%), which is nearly eight times greater than abortion patients nationally. However, this is to be expected given that the National Network of Abortion Funds' Tiller Fund **prioritizes funding pledges for patients who are requesting funds for second trimester procedures."**[2]



IMPACT

These demographic data are especially important in the context of requests for second-trimester funding, which increased over time. The increase in requests demonstrates how financial burdens imposed by existing policy restrictions on abortion are, in fact, delaying abortions, which **adversely impact single women and African American women at greater rates.**[2]

THE COST OF ABORTION IS RISING.

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As clinic expenses continue to increase, it is expected that abortion costs will also rise.[1] In terms of resources, patients in the current study had on average just over $500 to contribute to the costs of their abortion care, one-fourth the amount required to fund the average procedure that was requested for assistance through the Tiller Fund.[1] This suggests that **individual resources were limited and fell pointedly short of meeting the expense of the abortion**, a finding that has not previously been documented in the literature.[1]

ECONOMIC CIRCUMSTANCES

THE EFFECTS OF THESE POLICIES HAVE COMBINED TO CREATE A CLASS-BASED GAP IN THE REPRODUCTIVE HEALTH SYSTEM THAT OFTEN CANNOT BE BRIDGED BY PEOPLE WHO ARE STRUGGLING TO GET BY.[9,11]

Given that 42% of abortion patients can be categorized as poor and an additional 27% can be categorized as low-income,[5,6] any substantial costs, which do not take ancillary expenses such as childcare, travel and lodging into account, have a considerable impact on people seeking abortion.[4] Over one third of patients seeking funding from the Tiller Fund reported receiving some form of public assistance, which includes a range of programs such as SNAP (food stamps), WIC or unemployment benefits.[4] And 40% of patients seeking funding had two or more children.[4]

These findings point to the broader economic circumstances experienced by abortion fund patients and are consistent with other findings suggesting that people already on public assistance are more likely to get an abortion when faced with unintended pregnancy.[4,7] This is also consistent with findings indicating that public assistance recipients already experience a wide range of "megastressors" that cause impairments that are difficult to address.[4,5]

Policies that cause an undue burden of paying for an abortion contribute to delaying abortions, which elevate both cost and risk, and also eliminate the option of medical abortion for many.[2] For low-income people, obtaining costs for a procedure may take weeks or months, forcing patients to travel greater distances to providers who offer services for late stage procedures.

Federal public policy in the United States restricts public funding of abortion, which is a primary cause of high out-of-pocket costs associated with abortion care. State level restrictions on abortion, which include mandatory wait periods and bans on private insurance coverage also create significant cost barriers for many seeking the procedure.[8,9] **The effects of these policies have combined to create a class-based gap in the reproductive health system that often cannot be bridged by people who are struggling to get by.**[8,10]

DISTANCE TRAVELED

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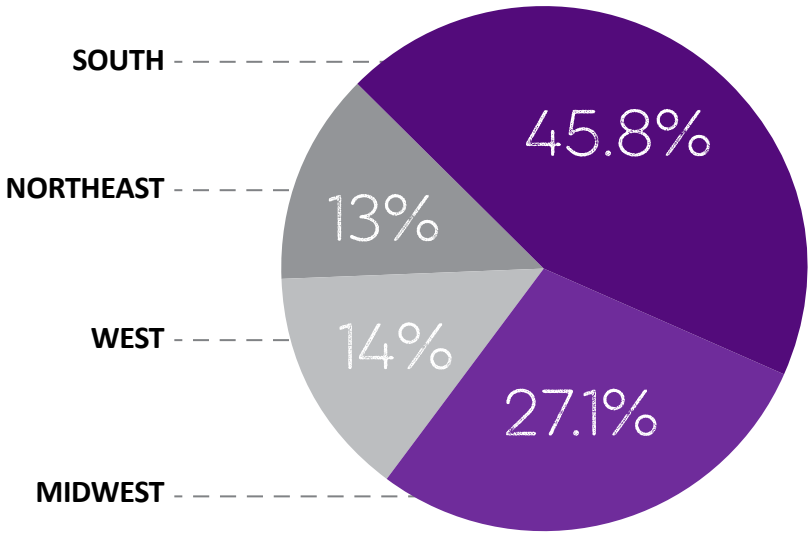
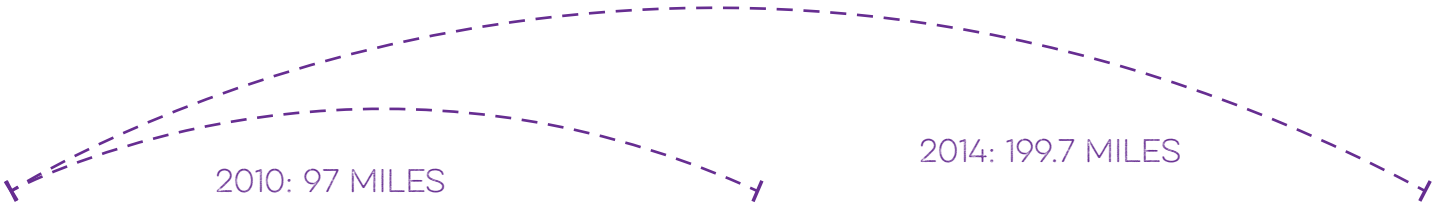
Out of nearly 2,000 people who called the Tiller Fund and gave geographic information, we learned that the majority of pledges are made to residents of states **without expanded Medicaid access** to abortion and states that have private insurance restrictions on abortion coverage. **Most of the people who were funded were residents of the South** followed by residents of the Midwest.[3]

The standardized percentiles were as follows: South = 45.8; Midwest = 27.1; West = 14.2; Northeast = 12.9. The standardized percentage for states exceeding Medicaid requirements was 26.4 while the standardized percentage for states meeting the federal requirements was 73.6.[3]





Over the years, those who received funding pledges anticipated traveling over 140 miles on average to access the abortion. However, the distance to be traveled doubled for callers to the Tiller Fund from 2010 to 2014.[3]

People seeking second trimester procedures traveled three times farther than people in their first term to access the procedure.

These increases in travel distance suggests that abortion access in these geographic regions is becoming more difficult as policy based restrictions continue to build.[3]

Regions were divided based on the divisions used in U.S. Census Bureau (n.d.). Economic census: Regions and divisions. http://www.census.gov/econ/census/help/geography/regions_and_divisions.html

TRAUMA-INFORMED STUDY OF LIFE CIRCUMSTANCES

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The trauma caused by service seeking around abortion is not well-researched, but this report sheds some light on the life circumstances surrounding requests for abortion funding. Results suggest that abortion fund patients are experiencing a wide-range of hardships that are potentially traumatic, necessitating the consideration of a trauma-informed approach surrounding the abortion seeking experience in the United States.[3] Given the life circumstances reported by abortion fund patients, **there is an increased likelihood that the current environment for persons seeking abortion care is exacerbating pre-existent trauma.**[4]

We know there is potential for trauma that exists prior to pregnancy, as many unintended pregnancies occur in the context of partner violence, family problems, and economic distress.[3] There is also potential for trauma once one has decided to get an abortion, as much tenacity is needed to overcome personal, community, and policy hardships that can exacerbate existing trauma or cause new trauma. **Abortion restrictions can contribute to trauma by delaying the procedure, which often results in later abortions, or abortions being denied outright**.[4,10]

On average, persons in the sample experienced 2.29 (SD=1.13) of the life circumstances listed on the next page, with a range from 0 to 7. Out of the total sample of 3,999 cases, 82.8% (N=3,311) experienced at least one , over half of the sample experienced two or more (N=2,317; 57.9%), approximately one third of the sample experienced three or more (N=1,323; 33.1%), while some participants experienced four or more (N=515; 12.9%), five or more (N=112; 2.8%), six or more (N=12; 0.3%), and seven (N=2; 0.1%).[4]

African American patients experienced the greatest number of circumstances guiding their reproductive decision making per case on average, followed closely by white patients. Patients from the geographic South experienced the most circumstances, followed by those from the Midwest. The circumstances experienced by abortion fund patients are similar to those reported in other sample of abortion patients, and these have the potential to cause or exacerbate trauma.[4]

ONE WAY TO PROVIDE A TRAUMA-INFORMED APPROACH THAT REDUCES THE POTENTIAL FOR TRAUMA IN THE ABORTION EXPERIENCE WOULD BE TO SIMPLY FUND ABORTION WHEN PATIENTS CANNOT AFFORD CARE.[4]

ON AVERAGE, PERSONS IN THE SAMPLE OF 3,999 EXPERIENCED 2.29 LIFE CIRCUMSTANCES, WITH SOME UP TO 7.

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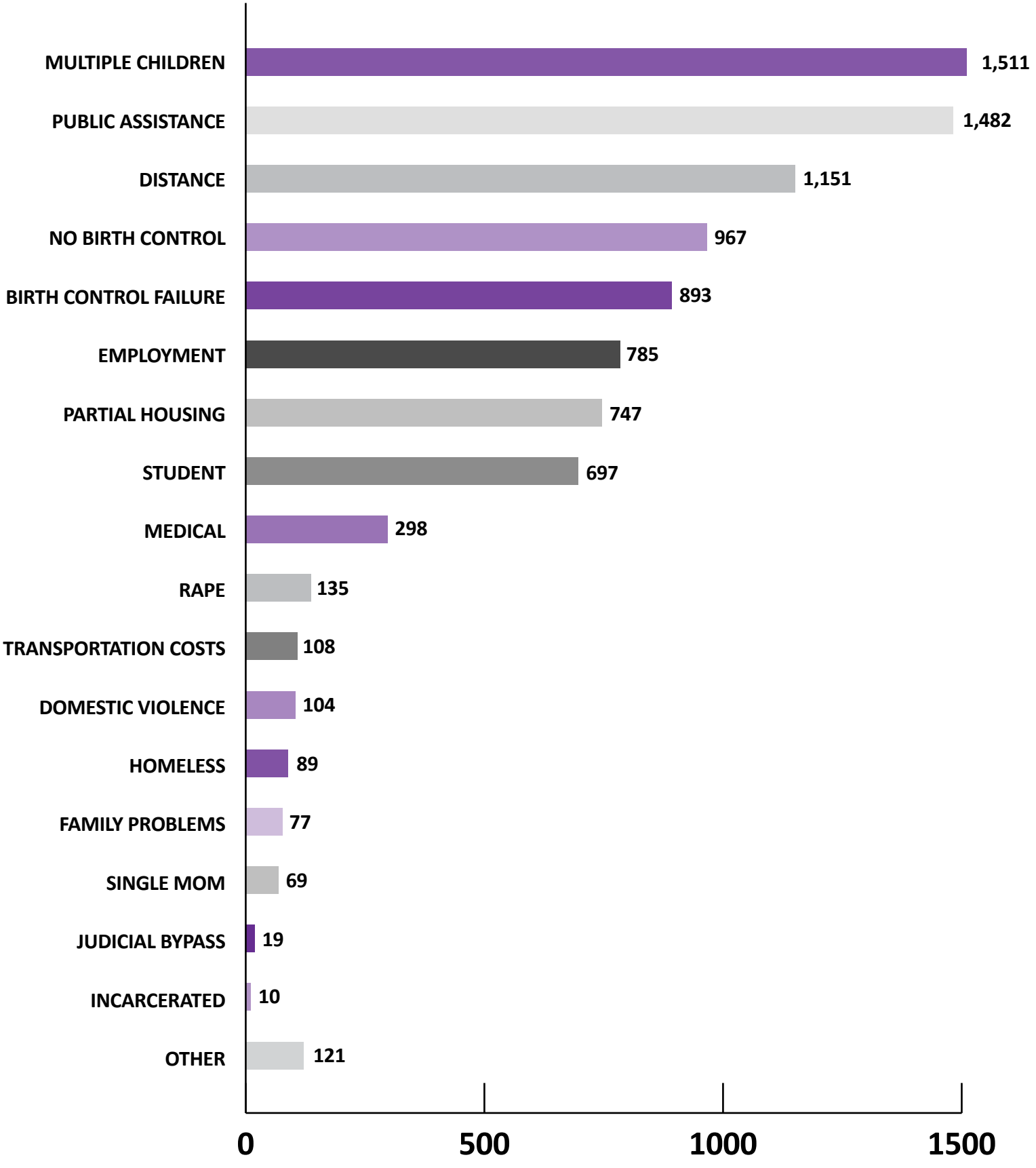

ENDING DISCRIMINATORY POLICIES

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In demonstrating the real-world, harmful effects of policies that restrict public funding of abortion or set up barriers to access, it is clear all such policies must come to an immediate end. With the increase in state and federal restrictions on abortions, this report shows that people who call the Tiller Fund seeking abortion funding are becoming increasingly burdened with the responsibility of procuring resources and obtaining access for appropriate care.[2] This report also shows the Tiller Fund has helped almost 4,000 patients who couldn't afford abortion on their own over a five year period, which suggests that there are a significant number of people receiving assistance because they can't afford abortion and there are likely many others who needed help aren't represented in the data.

As the barriers to access care increase, the time to obtain procedures increases thus further increasing costs and risk. As a result of this cycle, there are inevitably going to be patients who are priced out of access and thus forced to carry unwanted pregnancies to term, thus exacerbating the economic disparities they are already experiencing.[2,3,4]

These policies have the strongest influence on lower-income people who cannot readily afford procedural costs and are, therefore, discriminatory. With the increase in restrictive policies, patients served by the Tiller Fund are traveling greater distances to obtain adequate care. If not for the assistance provided by the National Network of Abortion Funds and member organizations, an abortion would have been financially out of reach for many of the people in this study.[2]

This disparity reveals classism in abortion restrictions that would have little impact on higher-income people with greater access to resources.[2] The finding that the sample is primarily single and African American represents the discriminatory effects of public policy that restricts public funding of abortion, demonstrating state and federally sanctioned classism and racism, which undermines a rational public health approach to reproductive health in the United States.[2]

This discrimination parallels discrimination present in reproductive healthcare access overall for these populations in the United States.[2] While the Hyde and Stupak amendments seek to limit abortion, they are actually impeding abortion access primarily for vulnerable groups of people, prohibiting funding of abortion at the federal level, resulting in prohibition of abortion funding through Medicaid, Medicare, the Affordable Care Act (ACA), Indian Health Services, Peace Corps and other federal volunteer programs, adolescents covered under the Children's Health Insurance Program, prison health programs, federal employee health programs and military health programs.[2,11]

The limits on abortion access, from barriers to coverage, present a host of public health concerns, the effects of which cannot be readily measured, and the institutionalized, policy-based discrimination creates a significant "undue burden" for these populations, which is a call to health advocates to dedicate time and attention to policy repeal in this area, at the state and federal level.[2,3]

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