

Issues & Implications

The Need for and Cost of Mandating Private Insurance Coverage of Contraception

by Rachel Benson Gold

With the issue of contraceptive coverage rapidly gaining public attention and political momentum, a central question is whether a government mandate on private, employment-related insurance coverage would constitute good public policy. The question largely boils down to whether a mandate, in this instance, is necessary to achieve an important public interest and whether it is justified in light of its fiscal impact on employers and employees.

Industry representatives oppose mandates in general, charging that they are unnecessary and serve mostly to drive up the costs of insurance coverage. Women's health advocates, on the other hand, argue that, whether from benign neglect or outright dis-

crimination, women traditionally have been disadvantaged in insurance coverage. They point to past examples where government mandates were necessary to secure coverage even of women's most basic health care needs and argue that similar action is required and appropriate now with regard to contraception.

Women and Insurance

As their most striking example of historic discrimination against women in insurance coverage, advocates cite maternity care—basic prenatal and delivery services—which, until the late 1970s, private insurance plans in the United States often did not cover. Indeed, it took enactment of a federal law—the Pregnancy Discrimination

Act of 1978 (PDA), which mandates maternity coverage in most private-sector policies—to change the situation. And change the situation it did: Coverage for maternity care jumped from 57% of policies written in 1977 to 89% of policies just five years later.

While the PDA undeniably played a major role in ending de facto insurance discrimination against women, advocates argue that the job is not done. Even now, according to the Women's Research and Education Institute, women of childbearing age spend 68% more in out-of-pocket health care costs than do men of the same age. Contraception, advocates contend, is now in the same position—maternity care was just 20 years ago—which is to say, it is basic health care for women that private insurance fails to adequately cover.

Gaps in Contraceptive Coverage

If a sexually active woman between ages 20 and 45 wants—as do most American women—two children, she will spend, on average, almost five years of her life trying to become pregnant, or being pregnant or postpartum, and more than four times that long trying to avoid pregnancy.

Overwhelmingly, American women use contraception to avoid unintended pregnancy. Among women aged 20–44 who have ever been sexually active, for instance, 85% have used oral contraceptives at some point in their lives. Among women with some form of private health insurance coverage who are at risk for unintended pregnancy, only 7% use no method of contraception.

Although American women clearly view contraception as basic to their lives, and their health care, health insurers in this country traditionally have not. While three-fourths of American women of childbearing age rely on private insurance, the extent to which they are covered for contraception can differ dramatically depending on their type of insurance,

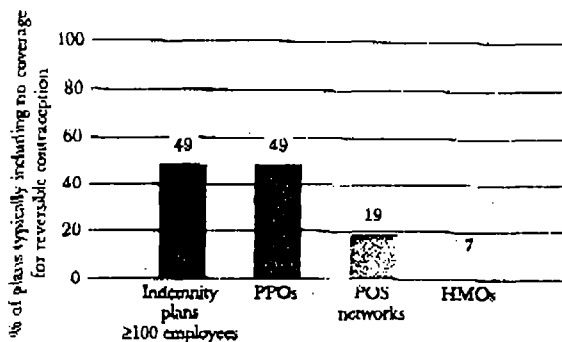
A Note from the Editor

After simmering slowly for a number of years, the effort to ensure comprehensive coverage of contraceptive services and supplies in private-sector, employment-related group health insurance plans has exploded. This year alone, nearly 20 states have addressed the issue—including Maryland, which enacted the first statewide coverage mandate this spring. For its part, Congress is on the verge of setting an important precedent for its own consideration of a federal mandate and, at the same time, an example for employers across the country: Last month, both houses passed bills requiring contraceptive coverage in the health insurance plans made available to federal employees (see For The Record, page 12). With momentum building, the contraceptive coverage debate is crystallizing around three key questions: the need for and cost of a government mandate; the appropriate scope of any exemption to a mandate that would be granted on grounds of conscience; and the methods that should be included in a mandate, specifically in terms of what constitutes "contraception" and what constitutes "abortion."

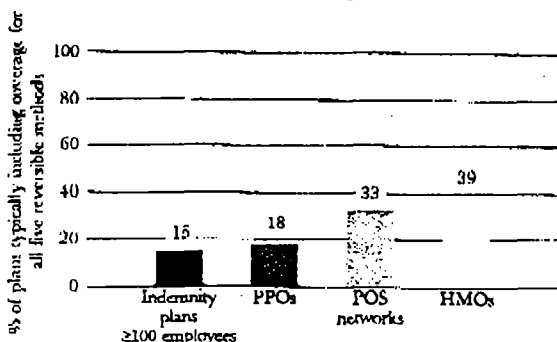
Beginning with this issue, The Guttmacher Report on Public Policy will examine these questions in a special series of articles supported in part by a grant from the Prospect Hill Foundation. The conclusions and opinions expressed in these analyses are those of the authors and The Alan Guttmacher Institute and do not necessarily represent the views of the foundation.

INADEQUATE COVERAGE

Many plans cover no contraception at all



*Few plans cover the five leading reversible methods**



*Oral contraceptives, IUD, Norplant®, Depo Provera®, diaphragm.

according to a 1994 study by The Alan Guttmacher Institute (AGI).

Traditional indemnity (fee-for-service) plans—which cover one in five privately insured Americans (18%), according to KPMG Peat Marwick—clearly provide the least comprehensive coverage for contraceptive services and supplies (see chart). Half of these policies typically cover none of the five leading reversible prescription contraceptive methods (IUD, diaphragm, hormonal implant [Norplant®], contraceptive injectable [Depo Provera®] and oral contraceptives), and only 15% cover all five methods. While 97% of indemnity plans cover prescription drugs in general, only 33% cover the costs of oral contraceptives, the most commonly used reversible contraceptive method in the United States.

Health maintenance organizations (HMOs), which cover one-third of

the market (33%), provide the most comprehensive contraceptive coverage of any type of insurance plan: Some 39% cover all five leading methods, and only 7% cover no contraception at all.

Newer types of managed care plans—which serve half the U.S. market—provide less extensive coverage than do HMOs. Preferred provider organizations (PPOs)—which cover almost as many Americans as do HMOs (31% of the market)—are closer to traditional indemnity plans in their coverage patterns; coverage in point of service (POS) networks is somewhat more comprehensive.

In sharp contrast, almost nine in 10 plans, regardless of plan type, cover sterilization services. And, about two-thirds routinely cover abortion.

Why Coverage is Important

According to a recent poll commissioned by the Kaiser Family Foundation (KFF), three in four adult women say cost is an important factor when choosing between a method that is covered and one that is not. In the absence of comprehensive coverage, many women may “choose” a method covered by their plan rather than one that might be more appropriate to their medical or life circumstances. The impact could be significant. Some methods, like the IUD and the contraceptive implant, Norplant®, have up-front costs that can be prohibitive for women without significant discretionary income; at the same time, they are among the most effective of all methods.

Similarly, cost concerns may affect how well women are able to use their chosen method. Some women may delay refilling a prescription for oral contraceptives, for example, or put off obtaining a Depo Provera® injection because of cash-flow problems. And even a brief gap in method use can have a major impact. Notably, half of the unintended pregnancies in

the United States are to women who are “using” contraception—but not always consistently or with maximum effectiveness.

Most dramatically, in the absence of insurance coverage some few women may forego contraceptive use entirely—and a sexually active woman not using contraception is many times more likely to become pregnant unintentionally than a woman who is. In any single year, 85 of 100 sexually active women not using a contraceptive method will become pregnant, in contrast to less than one-tenth that many of every 100 oral contraceptive users.

How Much Would It Cost?

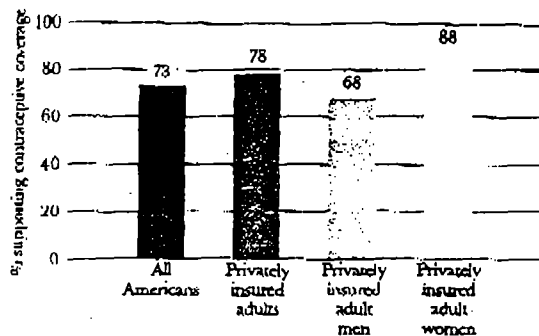
Central to any discussion of an insurance mandate is the question of its cost—specifically, whether the mandate will drive up the cost of insurance so much that coverage will become prohibitively expensive to some employers and their employees will suffer as a result.

New AGI estimates—based on the actual experience of plans that cover the cost of oral contraceptives (information obtained from pharmacy benefit managers administering plans covering over half the U.S. population) and on national data on use of other methods by privately insured women—show that the cost of covering the full range of FDA-approved reversible contraceptive methods is minimal. (The estimate does not include the costs of any associated medical services.)

Providing coverage for the full range of reversible contraceptive methods would result in a total cost of \$21.40 per employee per year. Assuming standard cost-sharing between employers and employees, employers would pay \$17.12, which translates into a monthly cost of \$1.43 per employee. This would increase employers' overall insurance costs by only 0.6%. Employees would contribute \$4.28 per year, or \$0.36 per month.

WIDESPREAD SUPPORT

Americans overwhelmingly support contraceptive coverage, even if it would increase their insurance costs by \$5 a month



Source: The Kaiser Family Foundation

As minimal as these costs are, they would only be borne in their entirety by a plan that does not now cover any of these reversible methods. The cost would be less for those plans that cover at least some of these methods, and there would be no added costs for the many plans that currently cover the full range of FDA-approved reversible contraceptive methods.

Support for Contraceptive Coverage

According to the recent KFF poll, America's public overwhelmingly supports mandating contraceptive insurance coverage (see chart). Eight in 10 privately insured adults (78%), support contraceptive coverage, even if it were to mean that their insurance costs would increase by as much as \$5 a month—almost 14 times the actual cost to individuals of a contraceptive coverage mandate. Support for contraceptive coverage rises to 88% among privately insured women.

In addition, seven in 10 privately insured Americans (71%)—and eight in 10 insured women (79%)—believe that a mandate should require coverage of all FDA-approved contraceptive methods.

Industry Perspectives

As noted, the U.S. insurance industry opposes governmental mandates across-the-board on philosophical grounds. At the same time, it fights

harder against some than others. The industry is now considering its options amid clear signs that the contraceptive coverage issue is resonating among the public and politicians alike—and that the costs of a mandate are minimal.

In that light, many observers found it significant that, even as Congress was moving last month to mandate contraceptive coverage for federal employees, the Health Insurance Association of America (HIAA) declined an invitation to present its position at a Senate hearing on the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC). Authored by Sens. Olympia Snowe (R-ME) and Harry Reid (D-NV), EPICC would require coverage nationwide in private, employment-related plans. Instead, HIAA President Willis Gradison (himself a former Member of Congress) was quoted by *Washington Post* reporter and syndicated columnist David Broder as saying, "We oppose mandates, but we're not going to spend a dime fighting this." ☺

Child Custody Protection Act... Continued from page 2

over which states are divided, it would be unprecedented for the federal government to take sides and help one state enforce its policies across borders, while providing no such assistance to a state with an opposing view. Sen. Patrick Leahy (D-VT) has emphasized this point, arguing that "[J]ust because some in Congress may prefer the policies of one State over those in Vermont, does not mean we should give those policies federal enforcement authority across the nation."

As an example, Leahy pointed out that Vermont allows the carrying of concealed weapons without a permit, while Massachusetts' law bars that practice. "When Vermonters

travel to neighboring states and across the nation, we understand that we must conform our behavior to the laws of the States we visit. When residents of each State may carry with them only the laws of their own State, they may be advantaged or disadvantaged but one thing is clear: We will have turned our federal system on its ear."

Looking Ahead

The overwhelming margin by which the House endorsed the CCRA—the vote was 276-159—amply demonstrates the extent to which abortion foes have mainstream appeal going for them on this issue. In their strategic calculations, bill proponents probably also did not overlook the fact that President Clinton signed a mandatory parental notice law while governor of Arkansas.

Indeed, the White House has indicated a particular sensitivity to this measure: In a Statement of Administration Policy (SAP), it suggested the president could support "properly crafted" legislation that was amended to exclude close family members from criminal and civil liability as well as protect persons who only provide information, counseling, referral or medical services.

As with the pending ban on "partial-birth" abortion, which the president also has said he would sign if it were modified only slightly to include an exception to protect the woman's health, antiabortion leaders are unlikely to take up the president's challenge. Apparently they have made the political calculation that, new law or not, they have a winning horse to ride into the fall campaigns. ☺

S 743 IS

105th CONGRESS

1st Session

S. 743

To require equitable coverage of prescription contraceptive drugs and devices, and contraceptive services under health plans.

IN THE SENATE OF THE UNITED STATES

May 14, 1997

Ms. SNOWE (for herself, Mr. REID, Mr. WARNER, Ms. MIKULSKI, Mr. CHAFEE, Mr. DURBIN, Ms. COLLINS, Mrs. MURRAY, and Mr. JEFFORDS) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To require equitable coverage of prescription contraceptive drugs and devices, and contraceptive services under health plans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the 'Equity in Prescription Insurance and Contraceptive Coverage Act of 1997'.

SEC. 2. FINDINGS.

Congress finds that--

- (1) each year, approximately 3,600,000 pregnancies, or nearly 60 percent of all pregnancies, in this country are unintended;
- (2) contraceptive services are part of basic health care, allowing families to both adequately space desired pregnancies and avoid unintended pregnancy;
- (3) studies show that contraceptives are cost-effective: for every \$1 of public funds invested in family planning, \$4 to \$14 of public funds is saved in pregnancy and health care-related costs;
- (4) by reducing rates of unintended pregnancy, contraceptives help reduce the need for abortion;
- (5) unintended pregnancies lead to higher rates of infant mortality, low-birth weight, and maternal morbidity, and threaten the economic viability of families;
- (6) the National Commission to Prevent Infant Mortality determined that 'infant mortality could be reduced by 10 percent if all women not desiring pregnancy used contraception';

- (7) most women in the United States, including two-thirds of women of childbearing age, rely on some form of private employment-related insurance (through either their own employer or a family member's employer) to defray their medical expenses;
- (8) the vast majority of private insurers cover prescription drugs, but many exclude coverage for prescription contraceptives;
- (9) private insurance provides extremely limited coverage of contraceptives: half of traditional indemnity plans and preferred provider organizations, 20 percent of point-of-service networks, and 7 percent of health maintenance organizations cover no contraceptive methods other than sterilization;
- (10) women of reproductive age spend 68 percent more than men on out-of-pocket health care costs, with contraceptives and reproductive health care services accounting for much of the difference;
- (11) the lack of contraceptive coverage in health insurance places many effective forms of contraceptives beyond the financial reach of many women, leading to unintended pregnancies; and
- (12) the Institute of Medicine Committee on Unintended Pregnancy recently recommended that 'financial barriers to contraception be reduced by increasing the proportion of all health insurance policies that cover contraceptive services and supplies'.

SEC. 3. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL- Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as added by section 603(a) of the Newborns' and Mothers' Health Protection Act of 1996 and amended by section 702(a) of the Mental Health Parity Act of 1996) is further amended by adding at the end the following new section:

'SEC. 713. STANDARDS RELATING TO BENEFITS FOR CONTRACEPTIVES.

'(a) REQUIREMENTS FOR COVERAGE- A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not--

'(1) exclude or restrict benefits for prescription contraceptive drugs or devices approved by the Food and Drug Administration, or generic equivalents approved as substitutable by the Food and Drug Administration, if such plan provides benefits for other outpatient prescription drugs or devices; or

'(2) exclude or restrict benefits for outpatient contraceptive services if such plan provides benefits for other outpatient services provided by a health care professional (referred to in this section as 'outpatient health care services').

'(b) PROHIBITIONS- A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not--

'(1) deny to an individual eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan because of the individual's or enrollee's use or potential use of items or services that are covered in accordance with the requirements of this section;

'(2) provide monetary payments or rebates to a covered individual to encourage such individual to accept less than the minimum protections available under this section;

`(3) penalize or otherwise reduce or limit the reimbursement of a health care professional because such professional prescribed contraceptive drugs or devices, or provided contraceptive services, described in subsection (a), in accordance with this section; or

`(4) provide incentives (monetary or otherwise) to a health care professional to induce such professional to withhold from a covered individual contraceptive drugs or devices, or contraceptive services, described in subsection (a).

`(c) RULES OF CONSTRUCTION-

`(1) IN GENERAL- Nothing in this section shall be construed--

`(A) as preventing a group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan from imposing deductibles, coinsurance, or other cost-sharing or limitations in relation to--

`(i) benefits for contraceptive drugs under the plan, except that such a deductible, coinsurance, or other cost-sharing or limitation for any such drug may not be greater than such a deductible, coinsurance, or cost-sharing or limitation for any outpatient prescription drug otherwise covered under the plan;

`(ii) benefits for contraceptive devices under the plan, except that such a deductible, coinsurance, or other cost-sharing or limitation for any such device may not be greater than such a deductible, coinsurance, or cost-sharing or limitation for any outpatient prescription device otherwise covered under the plan; and

`(iii) benefits for outpatient contraceptive services under the plan, except that such a deductible, coinsurance, or other cost-sharing or limitation for any such service may not be greater than such a deductible, coinsurance, or cost-sharing or limitation for any outpatient health care service otherwise covered under the plan; and

`(B) as requiring a group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan to cover experimental or investigational contraceptive drugs or devices, or experimental or investigational contraceptive services, described in subsection (a), except to the extent that the plan or issuer provides coverage for other experimental or investigational outpatient prescription drugs or devices, or experimental or investigational outpatient health care services.

`(2) LIMITATIONS- As used in paragraph (1), the term 'limitation' includes--

`(A) in the case of a contraceptive drug or device, restricting the type of health care professionals that may prescribe such drugs or devices, utilization review provisions, and limits on the volume of prescription drugs or devices that may be obtained on the basis of a single consultation with a professional; or

`(B) in the case of an outpatient contraceptive service, restricting the type of health care professionals that may provide such services, utilization review provisions, requirements relating to second opinions prior to the coverage of such services, and requirements relating to preauthorizations prior to the coverage of such services.

`(d) NOTICE UNDER GROUP HEALTH PLAN- The imposition of the requirements of this section shall be treated as a material modification in the terms of the plan described in section 102(a)(1), for purposes of assuring notice of such requirements under the plan, except that the summary description required to be provided under the last sentence of section 104(b)(1) with

respect to such modification shall be provided by not later than 60 days after the first day of the first plan year in which such requirements apply.

`(e) PREEMPTION- Nothing in this section shall be construed to preempt any provision of State law to the

extent that such State law establishes, implements, or continues in effect any standard or requirement that provides protections for enrollees that are greater than the protections provided under this section.

`(f) DEFINITION- In this section, the term 'outpatient contraceptive services' means consultations, examinations, procedures, and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.'

(b) CLERICAL AMENDMENT- The table of contents in section 1 of such Act, as amended by section 603 of the Newborns' and Mothers' Health Protection Act of 1996 and section 702 of the Mental Health Parity Act of 1996, is amended by inserting after the item relating to section 712 the following new item:

`Sec. 713. Standards relating to benefits for contraceptives.'

(c) EFFECTIVE DATE- The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 1998.

SEC. 4. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.

(a) IN GENERAL- Subpart 2 of part A of title XXVII of the Public Health Service Act (as added by section 604(a) of the Newborns' and Mothers' Health Protection Act of 1996 and amended by section 703(a) of the Mental Health Parity Act of 1996) is further amended by adding at the end the following new section:

`SEC. 2706. STANDARDS RELATING TO BENEFITS FOR CONTRACEPTIVES.

`(a) REQUIREMENTS FOR COVERAGE- A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not--

`(1) exclude or restrict benefits for prescription contraceptive drugs or devices approved by the Food and Drug Administration, or generic equivalents approved as substitutable by the Food and Drug Administration, if such plan provides benefits for other outpatient prescription drugs or devices; or

`(2) exclude or restrict benefits for outpatient contraceptive services if such plan provides benefits for other outpatient services provided by a health care professional (referred to in this section as 'outpatient health care services').

`(b) PROHIBITIONS- A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not--

`(1) deny to an individual eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan because of the individual's or enrollee's use or potential use of items or services that are covered in accordance with the requirements of this section;

`(2) provide monetary payments or rebates to a covered individual to encourage such individual to accept less than the minimum protections available under this section;

`(3) penalize or otherwise reduce or limit the reimbursement of a health care professional because such professional prescribed contraceptive drugs or devices, or provided contraceptive services, described in subsection (a), in accordance with this section; or

`(4) provide incentives (monetary or otherwise) to a health care professional to induce such professional to withhold from a covered individual contraceptive drugs or devices, or contraceptive services, described in subsection (a).

`(c) RULES OF CONSTRUCTION-

`(1) IN GENERAL- Nothing in this section shall be construed--

`(A) as preventing a group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan from imposing deductibles, coinsurance, or other cost-sharing or limitations in relation to--

`(i) benefits for contraceptive drugs under the plan, except that such a deductible, coinsurance, or other cost-sharing or limitation for any such drug may not be greater than such a deductible, coinsurance, or cost-sharing or limitation for any outpatient prescription drug otherwise covered under the plan;

`(ii) benefits for contraceptive devices under the plan, except that such a deductible, coinsurance, or other cost-sharing or limitation for any such device may not be greater than such a deductible, coinsurance, or cost-sharing or limitation for any outpatient prescription device otherwise covered under the plan; and

`(iii) benefits for outpatient contraceptive services under the plan, except that such a deductible, coinsurance, or other cost-sharing or limitation for any such service may not be greater than such a deductible, coinsurance, or cost-sharing or limitation for any outpatient health care

service otherwise covered under the plan; and

`(B) as requiring a group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan to cover experimental or investigational contraceptive drugs or devices, or experimental or investigational contraceptive services, described in subsection (a), except to the extent that the plan or issuer provides coverage for other experimental or investigational outpatient prescription drugs or devices, or experimental or investigational outpatient health care services.

`(2) LIMITATIONS- As used in paragraph (1), the term 'limitation' includes--

`(A) in the case of a contraceptive drug or device, restricting the type of health care professionals that may prescribe such drugs or devices, utilization review provisions, and limits on the volume of prescription drugs or devices that may be obtained on the basis of a single consultation with a professional; or

`(B) in the case of an outpatient contraceptive service, restricting the type of health care professionals that may provide such services, utilization review provisions, requirements relating to second opinions prior to the coverage of such services, and requirements relating to preauthorizations prior to the coverage of such services.

`(d) NOTICE- A group health plan under this part shall comply with the notice requirement under section 713(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this section as if such section applied to such plan.

'(e) PREEMPTION- Nothing in this section shall be construed to preempt any provision of State law to the extent that such State law establishes, implements, or continues in effect any standard or requirement that provides protections for enrollees that are greater than the protections provided under this section.

'(f) DEFINITION- In this section, the term 'outpatient contraceptive services' means consultations, examinations, procedures, and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.'.

(b) EFFECTIVE DATE- The amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.

SEC. 5. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE INDIVIDUAL MARKET.

(a) IN GENERAL- Subpart 3 of part B of title XXVII of the Public Health Service Act (as added by section 605(a) of the Newborn's and Mother's Health Protection Act of 1996) is amended by adding at the end the following new section:

'SEC. 2752. STANDARDS RELATING TO BENEFITS FOR CONTRACEPTIVES.

'The provisions of section 2706 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.'.

(b) EFFECTIVE DATE- The amendment made by this section shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 1998.

END

Bill Summary & Status for the 105th Congress

Item 35 of 94

PREVIOUS BILL | NEXT BILL**PREVIOUS BILL:COSPONSORS | NEXT BILL:COSPONSORS****NEW SEARCH | HOME | HELP | ABOUT COSPONSORS**

S.743SPONSOR: Sen Snowe (introduced 05/14/97)RELATED BILLS: S.766 H.R.2174

COSPONSORS(8):Sen Reid - 05/14/97 Sen Warner - 05/14/97Sen Mikulski - 05/14/97 Sen Chafee - 05/14/97Sen Durbin - 05/14/97 Sen Collins - 05/14/97Sen Murray - 05/14/97 Sen Jeffords - 05/14/97

Bill Summary & Status for the 105th Congress*House Companion bill***NEW SEARCH | HOME | HELP | ABOUT COSPONSORS****H.R.2174**SPONSOR: Rep Greenwood (introduced 07/16/97)RELATED BILLS: S.743 S.766**COSPONSORS(128):**

<u>Rep Molinari</u> - 07/16/97	<u>Rep Lowey</u> - 07/16/97
<u>Rep Waxman</u> - 07/16/97	<u>Rep Horn</u> - 07/16/97
<u>Rep Shays</u> - 07/16/97	<u>Rep Bilbray</u> - 07/16/97
<u>Rep Morella</u> - 07/16/97	<u>Rep Woolsey</u> - 07/16/97
<u>Rep Cook</u> - 07/16/97	<u>Rep Kennelly</u> - 07/16/97
<u>Rep Eshoo</u> - 07/17/97	<u>Rep Boehlert</u> - 07/17/97
<u>Rep Bentsen</u> - 07/17/97	<u>Rep Tauscher</u> - 07/17/97
<u>Rep Hastings, Alcee</u> - 07/17/97	<u>Rep Jackson-Lee</u> - 07/17/97
<u>Rep Lantos</u> - 07/17/97	<u>Rep Farr</u> - 07/17/97
<u>Rep Kelly</u> - 07/28/97	<u>Rep Menendez</u> - 07/28/97
<u>Rep Ackerman</u> - 07/28/97	<u>Rep Berman</u> - 07/29/97
<u>Rep Olver</u> - 07/29/97	<u>Rep Frost</u> - 07/29/97
<u>Rep Baldacci</u> - 07/29/97	<u>Rep Barrett, T.</u> - 07/29/97
<u>Rep Capps, Walter</u> - 09/04/97	<u>Rep Stark</u> - 09/04/97
<u>Rep Lewis, John</u> - 09/04/97	<u>Rep DeGette</u> - 09/04/97
<u>Rep Meehan</u> - 09/04/97	<u>Rep Lofgren</u> - 09/04/97
<u>Rep Martinez</u> - 09/04/97	<u>Rep Gutierrez</u> - 09/04/97
<u>Rep Green</u> - 09/04/97	<u>Rep Frank</u> - 09/04/97
<u>Rep Kennedy, P.</u> - 09/04/97	<u>Rep Millender-McDonald</u> - 09/04/97
<u>Rep Skaggs</u> - 09/04/97	<u>Rep Blumenauer</u> - 09/04/97
<u>Rep Kennedy, J.</u> - 09/08/97	<u>Rep Rothman</u> - 09/08/97
<u>Rep Jackson, Jesse L., Jr.</u> - 09/16/97	<u>Rep Slaughter</u> - 09/16/97
<u>Rep Johnson, N.</u> - 09/18/97	<u>Rep Pallone</u> - 09/18/97
<u>Rep Conyers</u> - 09/18/97	<u>Rep Fazio</u> - 09/30/97
<u>Rep Rush</u> - 09/30/97	<u>Rep Norton</u> - 09/30/97
<u>Rep Matsui</u> - 09/30/97	<u>Rep Hinchey</u> - 09/30/97
<u>Rep McDermott</u> - 09/30/97	<u>Rep Schumer</u> - 09/30/97
<u>Rep DeLauro</u> - 09/30/97	<u>Rep Meek</u> - 09/30/97
<u>Rep Davis, D.</u> - 10/07/97	<u>Rep Boucher</u> - 10/07/97
<u>Rep Kilpatrick</u> - 10/07/97	<u>Rep Stabenow</u> - 10/07/97
<u>Rep Burr</u> - 10/29/97(withdrawn - 01/28/98)	<u>Rep Sherman</u> - 10/29/97
<u>Rep Abercrombie</u> - 10/29/97	<u>Rep Sandlin</u> - 10/29/97
<u>Rep DeFazio</u> - 10/29/97	<u>Rep Filner</u> - 11/06/97

Rep Harman - 11/06/97
Rep Maloney, C. - 11/06/97
Rep Rivers - 11/07/97
Rep Thurman - 11/07/97
Rep Pelosi - 02/03/98
Rep Edwards - 02/03/98
Rep Mink - 02/03/98
Rep Sawyer - 02/03/98
Rep Brown, G. - 02/03/98
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Rep Tierney - 03/04/98
Rep Clay - 03/04/98
Rep Torres - 03/31/98
Rep Traficant - 03/31/98
Rep Furse - 04/01/98
Rep Dixon - 04/29/98
Rep Miller, G. - 04/29/98
Rep Pastor - 05/20/98
Rep Engel - 05/20/98
Rep Lampson - 05/20/98
Rep Moran, James P. - 05/20/98
Rep Dicks - 05/20/98
Rep Etheridge - 05/21/98
Rep Peterson, C. - 06/05/98
Rep Wexler - 06/05/98
Rep Yates - 06/05/98
Rep Sabo - 06/25/98
Rep Ford - 07/14/98
Rep Markey - 09/15/98
Rep McCarthy, K. - 09/15/98
Rep Rangel - 10/08/98

Rep Allen - 11/06/97
Rep Gejdenson - 11/06/97
Rep Smith, Adam - 11/07/97
Rep Maloney, J. - 11/09/97
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Rep Sanchez - 03/04/98
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Rep Delahunt - 03/31/98
Rep Capps, Lois - 04/29/98
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Cost to Employer Health Plans of Covering Contraceptives

Summary, Methodology and Background

By Jacqueline E. Darroch

30TH
ANNIVERSARY
YEAR
THE ALAN
GUTTMACHER
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NEW YORK &
WASHINGTON

June 1998

Summary of Results

Legislation has been introduced in the U.S. House and the Senate and a number of states (and actually has already been enacted in the State of Maryland) to mandate that insurance plans cover reversible medical contraceptives to the same extent that other prescription drugs and supplies are covered. This would not only improve access, but would also allow for more even-handed provision of contraceptive methods, giving women more balanced selection of the method most appropriate to their particular preferences and needs, independent of its cost.

One question in the discussion over possible mandates is how much they would add to insurance premiums. Available data on method use do not indicate how the contraceptive supplies are paid for,¹ making it difficult to estimate reliably the cost of additional coverage from existing national data. However, such projections can be made based on information from plans that currently do cover these reversible medical contraceptives.

In order to inform the current discussion about the potential cost of requiring that contraceptives be covered the same way plans cover other prescription drugs and supplies, The Alan Guttmacher Institute (AGI) commissioned Buck Consultants, an employee benefit, actuarial and compensation consulting firm, to make more detailed and comprehensive estimates.²

Buck Consultants estimated that the average total cost (including administrative costs) of adding coverage for the full range of reversible medical contraceptives to health plans that do not currently cover them will increase total health coverage costs for employees and their dependents by \$21.40 per employee per year—\$17.12 of *employers'* costs and \$4.28 of *employees'* costs.

The added cost for employers of providing this coverage corresponds to \$1.43 per month, which represents a mean increase of less than 1% in employers' costs of providing employees with medical coverage. This figure is broken down by method as follows:

METHOD	COST TO EMPLOYER PER EMPLOYEE 1 PER YEAR
ORAL CONTRACEPTIVES	\$16.13
DIAPHRAGMS/CERVICAL CAPS	0.03
INJECTABLES	0.77
IMPLANTS	0.15
IUDs	0.04
TOTAL	\$17.12

The above estimation of costs takes into account:

- The number of prescriptions for oral contraceptives filled per employee per year in plans that currently cover oral contraceptive supplies—from third-party

organizations that administer drug plans covering over half the U.S. population;

- *The number of prescriptions for other methods filled per employee per year*—estimated from the oral contraceptive information, national data on contraceptive method use by women in private insurance plans and the length of time supplies for each method can be used;
- *The net unit cost to a health plan for each method, deducting an average employee copayment for those methods typically obtained at a pharmacy (oral contraceptives, the diaphragm and cervical cap)*—from the drug plan administrators for oral contraceptives and a pharmacy pricing reference for the other methods, with the average copayment taken from an industry benefits report;
- *Administrative expenses, including risk charges and profit, of health plans for the claims filed with them*—based on a health maintenance organization (HMO) and preferred provider organization (PPO) industry profile; and
- *Employee payments toward the cost of employment-based health benefits*—from a national survey of employer-sponsored health plans.

This estimate represents the average cost of adding coverage to a plan that now does not cover any of these nonpermanent contraceptive methods. The cost would be less for those plans that cover at least some of these methods—half of indemnity plans and as many as 90% of HMOs. In fact, the added expenses would be minimal for 6 in 10 POS (point of service) and HMO plans that already cover oral contraceptives but do not necessarily cover the other reversible medical methods. There would be no added costs for the one-third of POS and HMO plans that already cover all of these methods.

Methodology

Only the added costs of covering *contraceptive supplies* were estimated by Buck Consultants. The major part of the cost of the physician's services is generally covered as part of the office visit, and is not always separately identified as a contraceptive service.³ The costs of covering oral contraceptives were estimated directly from the actual experience of plans that currently cover the cost of oral contraceptives. Costs for other methods were estimated in a different way, because other reversible medical contraceptive devices are not always uniquely identified on physician bills or captured by health plan claims systems.

For oral contraceptives, information was obtained from six major pharmacy benefit managers covering nearly 150 million members (insured employees and their dependents)—over half the entire U.S. population. Pharmacy benefit managers are third-party organizations that administer drug benefits for insurers. They negotiate terms of reimbursement with the retailers and handle the administration of claims and reimbursements for the insurance plans. Data from these pharmacy benefit managers were used to estimate for 1998 the average number of prescriptions filled or refilled and the average cost for oral contraceptives per employee per year in plans that covered the method. The "per employee" figures included supplies and costs for the employee as well as for any spouse or other dependents.

The number of prescriptions filled or refilled (scripts) and the number of devices purchased (for the other reversible medical methods—diaphragms, cervical caps, injectables, implants and IUDs) were estimated based on the number of privately insured women using each of these methods relative to the number using oral contraceptives, adjusted for the number of units of each method needed to equal one year of use. The results were expressed as the average number of scripts or devices per 1,000 employees per year, i.e., the total number of prescriptions filled or refilled and devices dispensed in one year to everyone covered by a plan divided by the number of total employees.

The average number of scripts/devices per insured employee per year was estimated as

METHOD	SCRIPTS/DEVICES PER EMPLOYEE PER YEAR
ORAL CONTRACEPTIVES	0.78416
DIAPHRAGMS/CERVICAL CAPS	0.00246
INJECTABLES	0.01878
IMPLANTS	0.00035
IUDs	0.00016
TOTAL	0.80591

This average number of scripts/devices per employee per year takes into account:

- that some employees and their dependents do not purchase any nonpermanent medical contraceptive methods during a year,
- that some employees have more than one covered person in their family purchasing contraception, and
- that some users need more than one refill of their method and that others use methods that prevent pregnancy for more than one year.

From the pharmacy benefit managers' information, Buck Consultants estimated that the average cost to an insurance plan for one oral contraceptive script was \$22.27. This figure includes an adjustment for an average employee copayment of \$5.50 toward the total script price of \$27.77. The unit costs for the other methods were estimated as the published average wholesale price minus copayments of \$5.50 for diaphragms and cervical caps, the other methods that typically are obtained through a pharmacy rather than directly inserted or administered by a clinician.

The average net cost for these nonpermanent (reversible) medical contraceptives per employee per year was calculated as the average number of scripts/devices per employee per year multiplied by the average cost of each script or device after copayment.

These average costs per employee per year represent the amount the covering plan pays for these contraceptive supplies per employee per year. Their levels reflect the distribution of methods used by women covered by private insurance and the costs of each of these methods.

To arrive at the total cost per employee per year, Buck added an estimated 15.5% to these claim costs to cover plan administration and other plan costs. This resulted in a total cost per employee per year of adding coverage for these methods of \$21.40, of which an estimated 20% (\$4.28 per employee per year) would be transferred by employers to their employees and 80% (\$17.12) would be paid by employers. This added cost to employers of \$17.12 per employee per year represents an average increase of less than 1% in the projected 1998 cost to employers for medical coverage for their employees.

METHOD	COST PER EMPLOYEE PER YEAR		
	TOTAL	EMPLOYEE SHARE	NET COST TO EMPLOYER
ORAL			
CONTRACEPTIVES	\$20.16	\$4.03	\$16.13
DIAPHRAGMS/			
CERVICAL CAPS	0.04	0.01	0.03
INJECTABLES	0.97	0.19	0.77
IMPLANTS	0.19	0.04	0.15
IUDs	0.04	0.01	0.04
TOTAL	21.40	4.28	17.12

Background

In 1996, the Health Insurance Association of America (HIAA) presented estimates to the California Assembly Insurance Committee of the cost of oral contraceptive coverage. HIAA estimated that the cost of adding contraceptive coverage (for oral contraceptives only) to a drug plan would be \$16.20 per employee per year, or \$1.35 per month per employee. This figure was based on information from Tillinghast, an insurance industry and risk management consulting company associated with Towers Perrin, and assumed the following: (1) that oral contraceptives cost an average of \$25 per month, that employees pay an average \$5 copayment per prescription, for a net cost to a plan of \$20 per prescription, or \$240 for a year's supply of pills, and (2) that 45% of covered employees are female and that 15% of female employees to whom the benefit is available would use it, for a total of 6.75% of employees who would use oral contraceptives and purchase them through their insurance drug plan.⁴ However, no further methodology or information about the sources of these data has been made available. In addition, these figures do not include the cost of covering the other nonpermanent medical methods—diaphragms, cervical caps, injectables, implants and IUDs.

The issue of coverage for nonpermanent medical contraceptive methods in private insurance is one that affects most women, and their families, at some time during their lives. Three-quarters of U.S. women of reproductive age depend on private insurance for their medical care expenses. Recent fig-

ures show that in 1995, 74% of women aged 15-44 were covered by private insurance, 16% were enrolled in Medicaid and 2% were enrolled in CHAMPUS or other government insurance.⁵ Virtually all indemnity plans and many HMOs cover pregnancy and its outcomes. A 1993 survey of private insurance plans found that 97-98% of indemnity plans covering 100 or more employees and of HMOs routinely cover childbirth; 66% and 70%, respectively, routinely cover abortion, and 9 in 10 will pay for it under some circumstances.⁶ This coverage affects many women: 82% of women aged 40-44 have had at least one child,⁷ and 43% have had at least one induced abortion.⁸

Contraception is also an important medical issue in women's lives. If a woman is sexually active between ages 20 and 45 and wants 2 children (the typical number in the United States⁹), she will spend, on average, 20.5 years needing to use contraception and 4.5 years either trying to become pregnant or being pregnant or postpartum.¹⁰

Contraception is a need that cuts across sociodemographic groups. Among those aged 20-44 who have ever had sex, for instance, 85% have ever used oral contraceptives (see Table 1, page 9), the most commonly used nonpermanent method in the United States. This proportion varies only slightly by age, marital status, area and region of residence, parity, education and poverty level. Ever-use of the pill is reported by 88% and 84% of non-Hispanic white and black women aged 20-44 who have ever had sex, respectively, as well as by 75% of Hispanic women and 61% of other women. Some 88% of Protestant and 81% of Roman Catholic women have ever used the pill, along with 86% of those reporting no religious affiliation and 73% of those reporting other religions.

However, a 1993 survey found that half of indemnity plans for large groups and 7% of HMOs do not cover any nonpermanent contraception. Only 33% of these large indemnity plans, and 84% of HMOs, routinely cover the most commonly used nonpermanent method, the oral contraceptive pill. Some 42% of indemnity plans and 86% of HMOs provided coverage for the pill in some circumstances.¹¹ In 1996, the Washington Business Group on Health (WBGH) found that 53% of its members' HMO plans covered oral contraceptive pills, compared with 28-33% of their PPO/POS and fee-for-service plans.¹² (WBGH members include Fortune 500 and large public-sector employers.)

The AGI survey found that plans that do cover contraceptive services and/or supplies are often inconsistent in which methods they will cover, and have a pronounced bias toward covering permanent surgical methods. In 1993, 58% of large indemnity plans would not cover pills, 76% would not cover the implant and 82-85% would not cover injectable contraception or the diaphragm. About half of HMOs would not cover the diaphragm, implant or injectable, compared with 14% that did not cover pills. In contrast, about 9 in 10 large indemnity plans and HMOs cover permanent sterilization through tubal ligation and vasectomy.¹³

The cost of contraceptive services and supplies affects what providers women use and even the methods they choose. Women with family incomes under 200% of poverty who were using nonpermanent contraceptives in 1988 were about twice as likely as higher income users to go to a clinic when they made a family planning visit (55% vs. 26%).¹⁴ Among low-income women aged 18-35 who were surveyed in 1986, 89% said that cost was an important factor influencing their decision about what family planning provider to use; 41% of those who preferred a clinic said it was because of cost.¹⁵

Among clients using family planning clinics in 1991-1992, those who did not have Medicaid coverage (which pays for all methods of contraception) were one-12th as likely to get the contraceptive implant as were other women at the same clinics who were on Medicaid. And among the 60% of family planning agencies that did not even offer the method, 43% said this was due to the cost of the method and the inability of the agency or clients to pay for it.¹⁶ Among 129 patients enrolled in a study in Texas in which they obtained a free IUD, 47% said that they would not have been able and willing to pay the more than \$200 that the IUD actually cost if it had not been provided free of charge through the study.¹⁷ Women aged 18-44 in commercial and Medicaid managed care plans in 5 states were surveyed in 1996-1997; all were at risk for unintended pregnancy and not using contraceptive sterilization. Some 29% of them said that if cost and the need for referral were not a problem, they would like to learn more about other contraceptive methods; 44% of condom users and 23% of those using no method said they would be interested in learning about a medical contraceptive method.¹⁸

Method use and method choice have direct effects on whether or not a woman will have an unintended pregnancy, the costs of which are usually covered by private insurance. For instance, women using oral contraceptives are less than half as likely to become pregnant in a year's time as are those using condoms, and one-fourth as likely as couples using withdrawal, but they are more than 12 times as likely to become pregnant as women using implants or injectables or couples relying on tubal sterilization or vasectomy.¹⁹

Each year, 3.28 million women either give birth to a baby they had wanted to have at the time they conceived or have a planned pregnancy that ends in miscarriage. However, women who succeed in planning their pregnancies are only about half of all women who conceive. Some 3.04 million women experience an unintended pregnancy each year. These pregnancies result in 1.22 million unplanned births, 1.43 million induced abortions and 0.39 million miscarriages—unintended events with significant economic, personal and social costs. Some 53% of these unintended pregnancies are among women who experienced contraceptive failure—largely because they or their partner were not using their method consistently or correctly—and 47% are among those who were not using any method during the month they conceived.²⁰

Comparisons of use of highly effective methods with those that are more difficult to use successfully or with nonuse—in terms of unintended births, abortions and miscarriages, as well as STDs and other health side effects—clearly show that effective contraceptive use when couples are sexually active and do not want to have a child leads to better health and to lower health care costs.²¹ This makes contraceptive use a relevant issue for health care providers interested in reducing medical care costs.

The discrepancy between the spotty insurance coverage for contraceptive methods and the near-universal coverage for the most costly outcomes of poor contraceptive use raises numerous questions: about discrimination against (or at least unfairness to) women, who are most typically the contraceptive users; about effects of differential payment on users' choice of methods; and about the impact on whether they use any method at all. Indeed, this is why legislation has been introduced in the House and the Senate to mandate that private insurance plans cover nonpermanent medical contraceptive supplies to the extent that they cover other prescription drugs and devices.

Such a requirement would affect a large number of women and their partners, since almost everyone in the United States uses medical methods of contraception during their lives. The most recent figures, for 1995, indicate that 44.7 million women aged 15-44 were covered by private insurance sometime during the prior year (Table 2, page 10). Of these, 31.0 million were sexually active, would have been fertile if they were not using a contraceptive, were not pregnant, postpartum or trying to become pregnant, and did not want to have a child at the time. Some 9.7 million of these women were using nonpermanent medical methods of contraception—oral contraceptives (8.0 million), the diaphragm or cervical cap (0.7 million), injectable contraception (0.6 million), the implant (0.2 million) or the IUD (0.2 million). And, as shown above, the overwhelming majority of the 11.1 million privately insured women relying on contraceptive sterilization used such methods in the past, and many of those using nonmedical methods or no method will use them in the future.

Discussion

Contraceptive use is a standard part of Americans' lives. Almost everyone of reproductive age has been sexually active, and almost all of those who have been have used contraception during periods when they wanted to avoid having a child.²² Studies have shown the personal benefits of contraceptive use, in both health and economic terms, as opposed to the costs of unintended pregnancy—whether ending in abortion or in a mistimed or unwanted birth.²³

In light of this, excluding coverage for all or some medical methods of contraception from private insurance plans seems particularly incongruous. The analyses presented here illustrate that if all plans included contraceptive services and supplies in the same manner as other medical care and prescription drugs and devices, the total cost to employers who do not now cover reversible medical methods would be \$17 per employee per year, or less than 1% of current health care premiums.

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FROM:☐ JANE HORVATH☐ HOLLY BODE☐ SHARON CLARKIN☐ BOB GUIDOS☐ GREG JONES☐ ANDREA LEVARIO☒ ROGER MCCLUNG☐ TANISHA PARKER☐ JON RETZLAFF☐ MARC SMOLONSKY☐ STEPHANIE WILSON☐



CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, DC 20515

Marked up

S. 326

Dan L. Crippen
Director

March 17, 1999

Honorable James M. Jeffords
Chairman
Committee on Labor
and Human Resources
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

At your request, the Congressional Budget Office has prepared the enclosed cost estimate for S. 326, the Patients' Bill of Rights Act.

Sincerely,

A handwritten signature in dark ink, appearing to read 'D. Crippen'.

Dan L. Crippen

Enclosure

cc: **Honorable Edward M. Kennedy**
Ranking Minority Member



CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

March 17, 1999

S. 326

Patients' Bill of Rights Act

As introduced on January 28, 1999

SUMMARY

Title I of the Patients' Bill of Rights Act would amend the Employee Retirement Income Security Act (ERISA) to give members of self-insured health plans rights to obtain certain services, require group health plans and health insurance issuers to provide certain information to enrollees and potential enrollees, and establish internal and external review procedures for group health plans and health insurance issuers. Title II would require all health plans, health care providers, and other entities to protect the confidentiality of health information and would allow individuals to inspect and copy their own medical records. Title III would prohibit health plans from discriminating on the basis of genetic information. Title IV would redesignate the Agency for Health Care Policy and Research as the Agency for Healthcare Research and Quality and would reauthorize the agency.

The proposed patient protections and grievance procedures would increase the premiums for employer-sponsored health insurance, substitute non-taxable fringe benefits for taxable wages, and reduce federal receipts from income and payroll taxes. The Congressional Budget Office (CBO) estimates that these provisions would reduce federal tax revenues by \$20 million in 2000 and by \$0.5 billion over the 2000-2004 period.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated effect of the bill on direct spending and receipts is shown in Table 1. The costs of this legislation fall within budget function 550 (health).

Table 1. Estimate of the Budgetary Effects of S. 326, Patients' Bill of Rights Act

	By fiscal year, in billions of dollars									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Revenues										
Income and HI Payroll Taxes	a	a	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2
Social Security Payroll Taxes	a	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
Total	a	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3
Authorizations of Appropriations										
Healthcare Research and Quality	a	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.1	a

SOURCE: Congressional Budget Office.
NOTE: HI = Hospital Insurance.

a. Less than \$50 million.

BASIS OF ESTIMATE

Revenues

The proposed rights to medical care and advice, informational requirements, and grievance procedures would affect the federal budget through their effect on premiums for employer-sponsored health insurance. Although the rights to medical advice and care would apply only to self-insured ERISA plans, other plans are likely to be affected by them as well. Federal legislation to regulate a significant part of the health insurance market could stimulate action on the part of both states and health plans to develop consistent policies on coverage. Taking such spillover effects into account, CBO estimates that the provisions for medical care and advice, patient information, grievance procedures, and confidentiality of patient information would raise average premiums by about 0.5 percent. Table 2 shows the estimated effect of each provision on premiums, before employers modify their behavior to offset some of the increase. The effects are expressed as a percentage of total premiums for all nonfederal employer-sponsored plans, including plans that would face no increase in costs.

Why?
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TABLE 2. ESTIMATED EFFECT OF THE PATIENTS' BILL OF RIGHTS ACT ON PREMIUMS FOR EMPLOYER-SPONSORED HEALTH INSURANCE (In percents)

Provision	Increase in Premiums
Title I	
Subtitle A—Right to Medical Advice and Care	
Access to emergency care	0.1 <u>2</u>
Offering choice of coverage options	0.1 <u>.1</u>
Access to obstetric and gynecological care	a <u>.1</u>
Access to pediatric care	a
Continuity of care	0.1 <u>.2</u>
Protection of patient-provider communications	a
Subtitle B—Right to Information About Plans and Providers	0.1
Subtitle C—Right to Hold Health Plans Accountable	0.1 <u>.3</u>
Title II	
Personal Medical Information	a
Title III	
Genetic Information and Services	<u>a</u>
Total	0.5

a. Less than 0.05 percent.

The estimate assumes that about 60 percent of the increase in premiums would be offset through decreases in fringe benefits and that about 40 percent would be passed on to employees as lower wages. CBO estimates that the increase in premiums would reduce federal tax revenues by \$20 million in 2000 and by \$0.5 billion over the 2000-2004 period. Social Security payroll taxes, which are off-budget, account for about \$160 million of the five-year total.

Right to Medical Advice and Care. Subtitle A of title I contains a number of patient protections for enrollees in self-insured ERISA health plans. Those provisions include a prohibition against interference by health plans with medical communications between physicians and their patients, a requirement that plans pay for hospital emergency visits when the prudent layperson standard is met, a requirement for direct access to an obstetrical and

gynecological specialist for covered routine obstetrical and gynecological care, a requirement for direct access to pediatricians for covered routine pediatric services, the right to continue care for 90 days with a provider whose contract has been terminated by a health plan, and a requirement that health plans offer employees a point-of-service option when the existing health plan offerings do not provide choice among provider groups. CBO estimates that these rights to medical care and advice would ultimately increase costs across all nonfederal employer-sponsored health plans by about 0.1 percent.

Right to Information About Plans and Providers. Subtitle B of title I would require all ERISA group health plans to provide certain kinds of information on plan provisions to enrollees and to make other kinds available on request. Most of the required information is typically provided now as part of a plan's handbook or could easily be incorporated into that document. Although some documents would have to be amended to meet the requirements of this provision, such documents are continually changed to reflect new terms. Plans would be responsible for making available to participants any data on quality or performance that they collect, but they would not be required to collect such data. Plans would have to make minor investments in personnel and systems to assure and monitor compliance with those requirements. CBO estimates that the informational requirements would increase costs across all nonfederal employee sponsored health plans by slightly less than 0.1 percent.

Right to Hold Health Plans Accountable. Subtitle C of title I would require all ERISA group health plans to abide by specific time limits for making coverage determinations and to have an internal review process for reconsidering coverage decisions within defined time limits at the request of the enrollee. For those coverage decisions involving medical necessity or investigational treatments, a physician with the appropriate expertise would have to conduct the internal review. Plans would also have to provide for external review of medical necessity decisions involving claims exceeding a significant dollar threshold or investigational treatments for life threatening illnesses. The findings of the external review would be binding on the health plan.

Most plans today have a functioning internal appeals process, but they operate with more flexibility on timing than they might have under this provision. Consequently, a few plans would have to invest in more review personnel to meet the specified time limits. Costs would also increase because of the requirement for external review, which would be new to most plans. CBO estimates that the net cost of this subtitle would be 0.1 percent of employer-sponsored health plan costs.

Personal Medical Information. Title II would require health care providers, health plans, employers, health or life insurers, schools, and universities to provide a patient with access

to his or her medical records and allow the patient to request amendments to the record. These entities, as well as health oversight agencies, public health authorities, and health researchers would have to provide a written statement of their confidentiality policies. Along with law enforcement officials, they would also be required to implement appropriate safeguards to protect the confidentiality of individually identifiable health information.

The provisions regarding access to medical records would impose small administrative costs, most of which could be passed on to the requestor of the information through fees. The requirements for the protection of the confidentiality of health information might impose small costs on entities that do not already have such safeguards in place. CBO estimates that these provisions would increase premiums by less than 0.05 percent.

Genetic Information and Services. Title III would prohibit all health plans and health insurers from using predictive genetic information in setting premiums for groups or individuals. It would also prohibit plans from requesting such information except when the information was needed for diagnosis, treatment, or payment relating to the provision of health services. Even then, plans could not require such information and would have to provide the individual with a description of the procedures in place for protecting the confidentiality of such information. Although this provision would keep health insurers and health plans from reducing their costs through favorable risk selection based on genetic information, its cost to private employer-sponsored health plans as a whole would be negligible.

Authorizations of Appropriations

Healthcare Research and Quality. Title IV would redesignate the Agency for Healthcare Policy and Research as the Agency for Healthcare Research and Quality and respecify its mission. To support the activities of AHRQ, S. 326 would authorize \$185 million in fiscal year 2000 and such sums as may be necessary for fiscal years 2001-2006. Assuming appropriations of the authorized amounts, CBO estimates that this title would increase discretionary spending by about \$20 million in fiscal year 2000 and \$660 million over the 2000-2004 period.

PAY-AS-YOU-GO CONSIDERATIONS

Section 252 of the Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending and receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in Table 3. For purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

Table 3. Summary of Pay-As-You-Go Effects

	By Fiscal Year, in Millions of Dollars									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Change in outlays	0	0	0	0	0	0	0	0	0	0
Change in receipts	-20	-60	-100	-150	-200	-240	-250	-270	-280	-300

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

S. 326 would amend ERISA and the Public Health Service Act to establish a number of new requirements governing health care benefits and insurance. However, plans offered by state, local, and tribal governments are exempt from ERISA, and those governments would be able to opt out of the requirements under the Public Health Service Act. Consequently, these provisions would not be intergovernmental mandates as defined by UMRA, and they would have an impact on the budgets of state, local, or tribal governments only if those governments chose to comply.

S. 326 would require entities that provide health care services to permit an individual to inspect and copy protected health care information, with some exceptions regarding life and safety issues and confidentiality of external sources. The requirement to provide access would be an intergovernmental mandate for governmental health care providers. However, the cost of providing access to records would likely be minimal. The costs of copying the information could be passed on to the individual.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill would impose several private-sector mandates as defined in UMRA. They include the rights to medical care and advice, requirements to safeguard and grant patients access to their medical records, and requirements for plans to establish appeals procedures for handling patients' grievances. CBO estimates that the direct costs of those mandates to private-sector entities would significantly exceed the threshold specified in UMRA (\$100 million in 1996, adjusted annually for inflation) every year after 2000.

ESTIMATE PREPARED BY:

Federal Cost Estimate: Linda Bilheimer (226-2673), Tom Bradley (226-9010), Jeanne De Sa (226-9010), and Judith Wagner (226-2653)

Impact on State, Local, and Tribal Governments: Leo Lex (225-3220)

Impact on the Private Sector: Judith Wagner (226-2653)

ESTIMATE APPROVED BY:

Paul N. Van de Water
Assistant Director for Budget Analysis

**OFFICE FOR WOMEN'S INITIATIVES AND OUTREACH**TO: Sarah BianchiFAX: 6-5557DATE: 3/29/99NUMBER OF PAGES (INCLUDING COVER SHEET): 24

FROM: ☒ Jenny Luray, Director
☐ Sondra Seba, Agency Representative
☐ Robin Leeds, Agency Representative
☒ Kelley O'Dell, Special Assistant to the Director
☐ Other

NOTES:

This is the right one! Thanks!

THE WHITE HOUSE
OFFICE FOR WOMEN'S INITIATIVES AND OUTREACH
OLD EXECUTIVE OFFICE BUILDING, ROOM 15
WASHINGTON, DC 20502
PH: (202) 456-7300
FAX: (202) 456-7311
<http://www.whitehouse.gov/WH/EOP/Women/OWIO/>

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March 19, 1999

Mr. John Podesta
Chief of Staff
The White House
1st Floor, West Wing
Washington, D.C. 20502

Dear Mr. Podesta:

As supporters of family planning and equity in women's health care, the undersigned organizations are writing to ask the Administration to continue its long-standing support for both domestic and international family planning by endorsing the "Equity in Prescription Insurance and Contraceptive Coverage Act" (EPICC), a bill to remedy an existing gender inequity in private insurance coverage of contraceptives. The Administration's endorsement of EPICC would be a strong statement in opposition to this discriminatory treatment. It also would build upon the Administration's support last year for this same coverage for federal employees participating in FEBHP - support which was key to its inclusion in the FY 1999 omnibus appropriations bill.

As you are well aware, family planning is basic, preventive health care for American women, and most American women use family planning at some point in their reproductive years. However, many private insurance policies either exclude coverage for prescription contraceptives and related services entirely or single out these services for limited coverage. At the same time, almost all of these same policies offer coverage for prescription drugs and devices.

The exclusion of prescription contraceptive coverage makes little sense when the benefits of such services are examined. Timing and spacing births is critical in improving women's and children's health and avoiding unintended pregnancies. Pregnancies that are unintended, spaced too closely together, or occur very early or very late in a woman's reproductive years often have adverse health, social, or economic consequences for both women and children - consequences which can include lower levels of educational and job attainment as well as a greater risk for these families of living in poverty. The use of family planning also increases the likelihood that the estimated 15 million Americans who contract a sexually transmitted disease each year will be diagnosed and treated, and reduces the incidence of unintended pregnancy and abortion. The United States has an extremely high rate of unintended pregnancy compared with other developed countries - approximately half of all pregnancies in our country are unintended and half of these end in abortion. By improving and increasing access to a full range of contraceptive services, women's risk of unintended pregnancy is reduced, as is the rate of abortion.

Despite the myriad health and social benefits associated with contraception, it is the only non-experimental prescription drug benefit that is regularly excluded by insurers. Almost half of all fee-for-service plans and Preferred Provider Organizations (PPOs), 20 percent of Point-of-Service plans (POS), and seven percent of Health Maintenance Organizations (HMOs) do not offer any coverage for reversible contraception. Of those plans that do offer some coverage for contraception, many

do not cover all five major methods of reversible contraception. Fewer than 20 percent of fee-for-service plans or PPOs and fewer than 40 percent of POS networks and HMOs routinely cover all five major methods - oral contraceptives (OCs), diaphragms, intrauterine devices (IUDs), Norplant, and Depo Provera.

In an important step toward remedying this inequity, family planning advocates in Congress, along with the Administration, succeeded in providing contraceptive coverage to the 1.2 million women of reproductive age participating in the Federal Employees Health Benefits Program, the largest employer sponsored health insurance plan in the world. It is now time to expand this common sense provision to the rest of privately insured Americans - of whom more than eight in ten support contraceptive coverage.

Bipartisan legislation was introduced in 1997 and is about to be reintroduced in the 106th Congress to help remedy this fundamental inequity in health care coverage and to create a level playing field for American women and their families. The Senate bill will be sponsored by Senators Olympia Snowe (R-ME) and Harry Reid (D-NV), while the House bill will be sponsored by Representatives Jim Greenwood (R-PA) and Nita Lowey (D-NY). EPICC would require insurance plans that offer prescription drug coverage to cover prescription contraceptive drugs and devices. Similarly, the measure would require that health plans offering coverage for outpatient medical services also provide coverage for outpatient contraceptive services. The bill defines contraception as "consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy." Moreover, research indicates that the cost of such coverage would be minimal.

We would like to meet with you at your earliest convenience to discuss the Administration's endorsement of EPICC. Judith DeSarno, the President of NEPRHA, will be happy to serve as the contact point with the groups to set up the meeting. She can be reached at 293-3114.

Thank you for your consideration.

The Alan Guttmacher Institute
American College of Obstetricians and Gynecologists
American Association of University Women
American Nurses Association
Center for Reproductive Law and Policy
National Abortion and Reproductive Rights Action League
National Family Planning and Reproductive Health Association
National Partnership for Women and Families
National Women's Law Center
Planned Parenthood Federation of America

03/29/99 MON 12:27 FAX 2024587311
MAR-29-99 MON 12:52 PM

WH Womens Office

P.04

FROM : NFP & RND WASH DC

202 737 2690

1999-03-19

14:26

#237 P.04/04

cc:

Monica Dixon, Deputy Chief of Staff for Communications, Office of the Vice President
Maria Echaveste, Assistant to the President and Deputy Chief of Staff
Pat Ewing, Deputy Chief of Staff, Office of the Vice President
Audrey Tayse Haynes, Chief of Staff to Mrs. Gore
Christopher Jennings, Deputy Assistant to the Secretary for Health Policy
Elena Kagen, Deputy Assistant to the President for Domestic Policy
Ron Klain, Deputy Assistant to the President and Chief of Staff and Counselor to the Vice President
Jenny Luray, Deputy Assistant to the President and Director of Women's Initiatives and Outreach
Bruce Reed, Assistant to the Secretary for Domestic Policy
Melanne Verveer, Assistant to the President and Chief of Staff to the First Lady

MANDATORY BENEFITS

1. General Policy Concerns

Both OMB and HHS have general policy concerns about the wisdom of carving out individual benefits and requiring their coverage by private sector plans. They want a chance to voice those concerns.

2. Mental Health Benefits (Dominichi-Wellstone)

ASPE (Kevin Hennessey) and ASL (Andrea LaVario) have put together a small presentation on the Dominichi-Wellstone bill on mental health benefits. They will be able to speak to the differences between these proposals and the mental health parity law.

Because this legislation has not been introduced yet, OMB does not have a cost estimate.

SAMHSA discretionary totals are \$513.74 million in FY 99 and \$588.73 million in FY 2000.

Kevin mentioned briefly that the mental health community was split because of a provision in the Dominichi-Wellstone bill that somehow excludes anxiety disorders and other non-biologically based conditions. He will be ready to discuss this further.

3. Chemical Substance Abuse Treatment (Wellstone-Ramstead)

ASPE (Kevin Hennessey) and ASL (Andrea LaVario) have put together a small presentation on the Wellstone-Ramstead bill on chemical substance abuse treatment. They will be able to speak to the general differences between these proposals and the ONDCP proposal on this.

Because this legislation has not been introduced yet, OMB does not have a cost estimate.

The discretionary government wide total for substance abuse was \$3,015.6 million in FY 99 and \$3,193.3 million in the FY 2000 Budget. Of this total, HHS discretionary funding for substance abuse treatment was \$1,908 million in FY 99 and \$2,040 million in FY 2000.

4. Contraceptives (Snowe)

Jennie Luray will speak to this. Senator Snowe is planning to re-introduce her bill from last year.

Because this legislation has not been introduced yet, OMB does not have a cost estimate. However, Jennie has an estimate of the cost for this proposal that was done by an outside source, and it is minimal (\$21.40 per employee per year; \$17.12 for the employer and \$4.28 for the employee).

5. General Legislative Strategy

Has the Hill taken any action on our appropriations in these areas? When the proposed legislation by gets introduced, who is likely to pick it up? Which committees are likely to move these proposals along?

6. General Advocate Support

Families USA (Judy Waxman): Judy says that they've never taken a position on this type of bill. Although they certainly don't oppose mandated benefits, they would not go beyond what the mental health community would support, and if they are split, Families USA would stay out of the discussion altogether. Judy feels that they would probably support it only to be supportive of the other groups they work with.

Consumers Union (Gail Shear): Gail said that they would be wary of taking a position on this one unless they were pushed, because they are concerned about a possible rise in premiums and would prefer to address the issue of the uninsured first. Although they are also worried about the underinsured, they would probably prefer to see the issue of affordability addressed first, through mandating limits out of pocket expenditures, etc.

CONTRACEPTIVES

show planning to introduce w/ Reid;
didn't move last year b/c they were more
focused on FEHBP; strategy on senate
side attach to PBOR; Jeffords is a sponsor
& this goes through his committee; if a plan
has a prescription drug benefit, you have to
cover prescription contraceptives & devices
43% of indemnity plans cover oral contraceptives
only 40% HMOs cover all 5 of the leading
contraceptives; covers cost of inpatient visit
for fitting, etc. no abortion angle here @ all.
advocates want to change the language to
ensure that this doesn't include coverage
of abortion. Jennie will check & see if there
are empirical studies on this. trying to do CBO
score - Jeffords will fix it. Opting out any
plans - poss contraceptives Catholic plans
30 States have contraceptive coverage campaigns.

MENTAL HEALTH

attaching to PBOR but Dominicki will attach
to all/any budget bill.

.2% for substance abuse prem &
3% for mental health prem & (1-8%)
estimates vary by heavy managed care
plans.
1% for contraceptives

Chem after MH conf

MH MH conf

Contraceptives 3WK



ADMINISTRATION ON AGING

FACSIMILE COVER SHEET

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DATE: 4/27/99

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ORGANIZATION: _____

FAX NO.: _____

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NOTE:

*PER MOYA THOMPSON'S REQUEST
- AN ADDITIONAL Q+A FOR CHRIS*

We are transmitting 2 page(s) including this cover sheet. Please call us asap if you do not receive all pages.

NAME OF SENDER: EDWIN WALKER
TELEPHONE NO.: 619-1828



ELDER ABUSE

QUESTION:

Will the Administration's proposal to consolidate the activities under Title VII of the Older Americans Act lessen support for elder abuse?

ANSWER:

Recently, advocates have expressed concern about the proposal to consolidate the authorization of appropriations in Title VII. It should be noted that no concern was expressed when this was first proposed in 1997, and subsequently incorporated in our budget proposals.

Title VII of the Older Americans Act contains four activities, each with separate authorizations (ombudsman; elder abuse; legal services development; and outreach, counseling and assistance). Currently, only two of these activities (ombudsman and elder abuse) receive appropriations under the separate authorizations. Our proposal to consolidate the authorizations would provide states the flexibility to fund one or all of the four activities from the consolidated funds received. However, because our proposal would establish a floor for funding ombudsman activities, the only funds available for states to exercise this flexibility if there is no increase in the total appropriation, would be from the amount currently available under Title VII for elder abuse. This result could be interpreted by some as lessening our direct support for elder abuse activities.

It should be noted that we have retained all of the substantive provisions in the statute related to elder abuse. Under Title III, whenever the state desires to provide for the prevention of elder abuse, they shall assure us that area agencies conduct the program consistent with state law and coordinated with state adult protective service activities. Under Title II, we provide for the establishment and operation of a National Center on Elder Abuse for the purpose of compiling training materials, conducting research and demonstrations, and providing technical assistance related to the causes, prevention, identification, and treatment of elder abuse, neglect, and exploitation.

Chris Jennings
216 R

From:
Jenny Luray

MEMORANDUM

Date: 4/27/99

To: Chris, Elena, and Sarah

From: Jenny

Re: Conscience clause options – a starting point.

I've attached three different conscience clause provisions from bills that are being considered by state legislatures. Viable language would probably need to address the concerns of religious employers, health care plans, and individual medical providers. None of the provisions described below address all of these but they help to convey a sense of what such language might begin to look like.

I've also attached a helpful overview by the Allen Guttmacher Institute (AGI).

1. California

Religious employers may opt out but employees earning below a certain income level that work for such employers may obtain contraceptives through the state-funded family planning program. (Bill was vetoed by Gov. Wilson last year.)

2. Washington State

Religious employers can opt out but their employees can purchase contraceptive coverage directly from the employers' plan at a group rate.

3. Connecticut

Religious-based plans can opt out as long as contraceptive coverage is provided through another entity offering a limited benefit plan.

In addition, there are examples of religious-based plans adapting to contraceptive coverage requirements in both the Medicaid and private markets. According to AGI, a religious plan has contracted with an outside agency to administer the family planning benefits for its Medicaid enrollees. Another religious plan successfully bid on a private employer contract that required contraceptive coverage. The premiums go to an intermediary which divides the funds between the religious plan and a separate insurer that covers contraception, abortion and sterilization services. It would be helpful to have more information about how religious plans have addressed other health care services that go against their beliefs, such as sterilization.

Latest news is that bill may be dropped next week.

Issues & Implications

Contraceptive Coverage: Toward Ensuring Access While Respecting Conscience

By Rachel Benson Gold

Recent high-profile confrontations over requiring coverage of contraceptive services in insurance plans have raised long-standing, thorny "conscience" issues, albeit in a new context. But whether the debate is over coverage for federal employees or coverage for all private-sector employees, the central questions remain the same: What individuals or entities should be entitled to claim a conscientious objection to contraceptive coverage on what grounds, and how can the deleterious impact of those objections on individuals needing and entitled to services be minimized?

Government as Employer

This fall, the federal government took the crucial step of guaranteeing contraceptive coverage for its own employees in the largest employer-sponsored insurance program in the world, the Federal Employees Health Benefits Program (FEHBP). Clearly, grappling with the question of conscience was key to allowing the proposal to become a reality for the nine million enrollees in the program (see *For the Record*, page 12.)

As ultimately played out in the FEHBP debate, the conscience issue had two distinct aspects—the first regarding *health plans* that sign contracts as corporate entities with the Office of Personnel Management (OPM), the federal agency administering the insurance program, and the second regarding individual health care providers operating within those plans.

The first issue was by far the more contentious. Opponents of contra-

ceptive coverage argued for the widest possible conscience exemption—one that would allow *any* plan to decline to provide the coverage because of a "moral" objection to doing so. In order to guarantee access to the greatest number of enrollees, contraceptive coverage supporters pressed for the narrowest possible exemption—one that would permit only clearly *religious* plans to opt out of coverage. In the end, supporters prevailed; the final language allows an exemption only for plans that object to contraception "on the basis of religious beliefs."

As for individual health care providers operating within plans, the provision as enacted codifies the widely accepted standard that individual practitioners may decline to provide specific medical services if doing so would be contrary to their religious beliefs or "moral convictions."

Private Sector Challenges

As difficult as these questions were in the debate over the FEHBP, they become even more complex when the issue is not the federal government imposing a mandate on itself as

Models in both public policy and private-sector action indicate that the problems are not unsolvable.

an employer but, rather, federal or state policymakers imposing a mandate on private-sector coverage in general. Here, the balance between the perceived need to exempt some individuals and institutions from cov-

ering or providing contraceptive services on conscience grounds and the right of individual employees to obtain the coverage or care to which they are entitled is a tricky one. Given the specific players involved, it may be more or less difficult to achieve. Fortunately, there are sufficient models—in both public policy and private-sector action—to indicate that the problems are not unsolvable.

When Providers Opt Out

The question of an individual health care provider declining to provide a specific service does not pose an overwhelming obstacle to a patient's care in traditional fee-for-service plans in which the choice of provider is essentially unrestricted. However, when the context is a managed care plan, in which enrollees are limited to a specified network of providers, allowing individual providers to opt out raises more difficult issues.

The extent to which this is problematic may be eased somewhat by the long-standing and well-recognized obligation of managed care plans to make covered services accessible to enrollees. As articulated most recently by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry in its Patient Bill of Rights, this includes the obligation of the plan to ensure that adequate providers are available for all covered services: "All health plan networks should provide access to sufficient numbers and types of providers to assure that all covered services will be accessible without delay....If a health plan has an insufficient number or type of providers to provide a covered benefit with the appropriate degree of specialization, the plan should ensure that the consumer obtains the benefit outside the network at no greater cost than if the benefit were obtained from participating providers."

Indeed, this standard was reiterated by OPM in implementing the mandate for federal employees' coverage. OPM directed federal agencies to inform their employees that if an individual provider within a plan declines to provide contraception, they should contact the plan, which "will arrange for you to have access to a provider who will...."

When Employers Opt Out

The question of employers who may object to contraceptive coverage for their employees adds yet another dimension to an already complex situation. This question was moot in the FEHBP debate, where the employer—the federal government—clearly does not have a religious objection to contraception. In the general private sector, however, it is more difficult.

Here, as in the case with FEHBP plans, the goal should be crafting an exemption as narrowly as possible. This is because in the private sector, it is largely employers who choose

When a religious employer objects to contraceptive coverage, it does so for all its employees—many of whom may not share the employer's beliefs.

their employees' insurance plans. For example, when a large religious university—in its role as employer—claims a conscientious objection to contraception, it is making that choice for all of its employees, many of whom may have no affiliation whatsoever with the employer's religious beliefs.

The scope of an exemption for employers was very much at issue in the 12 states in which contraceptive coverage was seriously considered this year, including Maryland, where a measure was actually enacted, and California, where a measure passed

by both houses of the legislature was vetoed by the governor. All told, most of the states considering legislation chose to limit the exemption to religious employers, either "qualified church-controlled organizations" as defined by the U.S. tax code or, more generally, employers for whom covering contraception would conflict with "bona fide" religious tenets.

Thus far, California is the only state whose legislature has taken specific action designed to prevent individual employees from being disadvantaged as a result of a conscientious objection being invoked by their employer. As passed, the California contraceptive coverage mandate made employees whose employers objected to contraceptive coverage eligible for state-funded coverage, as part of a larger state-funded family planning program.

The California measure required that the employees in such situations be notified that their employer is a religious organization that has elected not to provide contraceptive coverage in its plan, and that they may be eligible to obtain services through the special state-funded program. The legislation went so far as to require that these employees be given the toll-free phone number for the state's family planning program.

While the California bill ultimately fell victim to the governor's veto pen (see *For The Record*, page 12), it stands as an important model for attempts to strike a balance between maintaining the ability of employers to adhere to religious doctrine in opposition to contraception and protecting the right of employees and their dependents not to be hurt as a result of their employers choosing to do so.

When Plans Opt Out

Finally, in the general private sector, the question of allowing plans to claim an exemption raises the question of how a religious plan that

objects to providing contraception can survive in a marketplace in which most employers are required to provide contraceptive coverage. In fact, numerous religious plans across the country have already been able to quietly craft their own solution in roughly analogous situations, allowing them to either participate in Medicaid programs that require coverage of contraception or compete in the private marketplace when contraceptive coverage is demanded by those seeking coverage. These solutions effectively keep the religious plan at sufficient arm's length from the actual provision of services to which they may object on religious grounds.

For example, a religious plan in the Southwest recently contracted with an outside agency to administer the family planning benefits for its Medicaid enrollees. (Under Medicaid, family planning is a mandated service to which enrollees are legally entitled.) The plan gives a portion of its Medicaid capitation payment to the outside agency, which in turn reimburses providers for the family planning services provided to enrollees. Individual providers within the plan sign independent contracts with this outside agency for family planning services only, and are reimbursed directly by it on a fee-for-service basis. Enrollees obtain care from their own plan providers, making the transition seamless from the enrollees' perspective.

In a letter to providers, the plan explained the balance it was seeking to strike, saying it "does not endorse these services nor are you required to provide them. However, these services must be available to our members."

Similarly, a Catholic-sponsored health plan in the Midwest has crafted an arrangement in a private-sector contract. Here, the plan sought to bid on a contract from a large corporation that required cov-

(Continued on page 14)

Issues & Implications**Contraceptive Coverage...***Continued from page 2*

erage of a range of reproductive health care services in its policy. To allow it to secure the contract, the plan arranged for the premiums to go first to an intermediary, which divides the funds between the plan and a separate insurer that has agreed to cover the contraception, abortion and sterilization services that the religious plan will not. To obtain these services, enrollees go to the providers listed in the plan's provider directory, and the charges for these services are billed to the separate insurer.

Both of these models allow religious plans to participate in a market where coverage of contraceptive services is required while distancing themselves somewhat from the provision of those services.

Contraceptive coverage language considered this year in Connecticut included such a "black box" option. The measure—which passed the Senate but stalled in the House—would have allowed a religious plan "to provide coverage of contracep-

Both in the context of Medicaid and the private market, religious plans have found ways to provide access to contraceptives while remaining "at arm's length" from them.

tive methods through another such entity offering a limited benefit plan; the cost, terms and availability of such coverage may not differ from that of other prescription coverage offered to the insured."

In short, the contraceptive coverage issue highlights a number of fault lines at the intersection of religious beliefs and the provision of health care services. As Congress and state legislatures continue to consider private-sector contraceptive coverage mandates, however, they should be aware that for each of the difficult issues that have been raised, creative thinking has pointed the way to at least the beginnings of some tenable options.

This is the third in a special series of articles examining key policy questions raised by the effort to require coverage of contraceptive services and supplies in private-sector insurance plans. These analyses are supported in part by a grant from the Prospect Hill Foundation. The conclusions and opinions expressed in them are those of the author and The Alan Guttmacher Institute and do not necessarily represent the views of the foundation. ⊕

THE GUTTMACHER REPORT

ON PUBLIC POLICY

December 1998

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CA Assembly Bill No. 1112

Passed the Assembly August 26, 1998

Chief Clerk of the Assembly

Passed the Senate August 12, 1998

Secretary of the Senate

This bill was received by the Governor this ____ day
of _____, 1998, at ____ o'clock ____

Private Secretary of the Governor

CHAPTER _____

An act to add Section 1367.25 to the Health and Safety Code, to add Section 10123.196 to the Insurance Code, and to amend Section 24003 of the Welfare and Institutions Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1112, Hertzberg. Health care coverage.

(1) Existing law provides for the licensure and regulation of health care service plans administered by the Commissioner of Corporations. Under existing law, a willful violation of any of these provisions is punishable as either a felony or a misdemeanor. Existing law also provides for the regulation of policies of disability insurance by the Insurance Commissioner.

Existing law requires that health care service plans and disability insurers provide coverage for certain benefits and services.

This bill would require certain group health care service plan contracts and certain group disability insurance policies, issued, amended, renewed, or delivered on or after January 1, 1999, and certain individual health care service plan contracts and certain individual policies of disability insurance of a type and form first offered for sale on and after January 1, 1999, to provide coverage, under terms and conditions applicable to other benefits, for a variety of federal Food and Drug Administration approved prescription contraceptive methods. This bill would exempt insurance policies or health care service plans provided by certain religious organizations, and their controlled religious subsidiaries, from this requirement. The bill would require, on and after July 1, 1999, these health care service plans and disability insurers to provide employees of these exempt employers with notice that contraceptive drugs and devices are available through the California State-Only Family Planning Program, for employees whose family has a gross annual household income equal to or less than

400% of the federal poverty level. The bill would require that program to make those benefits available to those people.

By changing the definition of the crime applicable to health care service plans, this bill would impose a state-mandated local program.

(2) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known and may be cited as the Women's Contraception Equity Act.

SEC. 2. Section 1367.25 is added to the Health and Safety Code, to read:

1367.25. (a) Every group health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 1999, and every individual health care service plan contract of a type and form first offered for sale on or after January 1, 1999, except for a specialized health care service plan contract, shall provide coverage for the following, under general terms and conditions applicable to all benefits:

(1) A health care service plan contract that provides coverage for outpatient prescription drug benefits shall include coverage for a variety of federal Food and Drug Administration approved prescription contraceptive methods, designated by the plan. In the event the patient's provider, acting within his or her scope of practice, determines that none of the methods designated by the plan is medically appropriate for the patient, the plan shall also provide coverage for another federal Food and Drug Administration approved, medically appropriate prescription contraceptive method prescribed by the patient's provider.

(2) Outpatient prescription benefits for an enrollee shall be the same for an enrollee's covered spouse and covered nonspouse dependents.

(b) Nothing in this section shall be construed to deny or restrict in any way any existing right or benefit provided under law or by contract.

(c) Nothing in this section shall be construed to require an individual or group health care service plan to cover experimental or investigational treatments.

→ (d) The requirements of this section shall not apply to a group health care service plan contract purchased by an employer that is a religious organization or a controlled religious subsidiary of a religious organization, including a church, religious institution, religious association, or other religious organization that is not organized for private profit and that is exempt from registering and reporting regularly to the Registry of Charitable Trusts in the Office of the Attorney General, as defined by Section 12580 and following of the Government Code, if the provision of prescription contraceptive methods as described in this section is inconsistent with the religious beliefs of the organization.

→ (e) Any enrolled employee whose family has a gross annual household income equal to or less than 400 percent of the federal poverty level, and his or her enrolled dependents, of an employer that elects not to provide coverage for prescription contraceptive methods as described in this section shall be eligible for a voucher, through the California State-Only Family Planning Program as established by Section 24000 of the Welfare and Institutions Code, for prescription contraceptive benefits as described in this section.

(f) On and after July 1, 1999, every health care service plan that contracts with an employer who meets the religious exemption provisions of subdivision (d) and who elects not to provide contraceptive coverage shall provide the following notice to all subscribers under that employer's group contract in a separate document or in the plan evidence of coverage, in at least 12-point type:

"HEALTH PLAN CONTRACEPTIVE COVERAGE

(1) California law requires health care service plans to include FDA-approved contraceptive drugs and devices in pharmaceutical benefit packages.

(2) California law exempts religious organizations from providing health benefit plans that include prescription contraceptive coverage.

(3) [The employer's name] is a religious organization or a controlled religious subsidiary and has elected not to provide contraceptive coverage to its employees.

(4) California law provides that covered employees who have a gross annual household income equal to or less than 400 percent of the federal poverty level, and their covered dependents, who work for an exempted religious organization or a controlled religious subsidiary electing not to provide the prescription contraceptive benefit shall be eligible for a voucher for this benefit through the California State-Only Family Planning Program, as authorized by Sections 24003 and 24007 of the Welfare and Institutions Code.

(5) If you are interested in this voucher for prescription contraceptive benefits, please contact the State Department of Health Services for more information. The department's "Family PACT" program's toll-free number is: (800) 942-1054."

SEC. 3. Section 10123.196 is added to the Insurance Code, immediately following Section 10123.195, to read:

10123.196. (a) Every group policy of disability insurance that covers hospital, medical, or surgical expenses, and that is issued, amended, renewed, or delivered on or after January 1, 1999, and every individual policy of disability insurance that covers hospital, medical, and surgical expenses and that is of a type and form first offered for sale on or after January 1, 1999, shall

provide coverage for the following, under general terms and conditions applicable to all benefits:

(1) A disability insurance policy that provides coverage for outpatient prescription drug benefits shall include coverage for a variety of federal Food and Drug Administration approved prescription contraceptive methods, designated by the insurer. In the event the patient's provider, acting within his or her scope of practice, determines that none of the methods designated by the insurer is medically appropriate for the patient, the insurer shall also provide coverage for another federal Food and Drug Administration approved, medically appropriate prescription contraceptive method prescribed by the patient's provider.

(2) Outpatient prescription benefits for an insured shall be the same for an insured's covered spouse and covered nonspouse dependents.

(b) Nothing in this section shall be construed to deny or restrict in any way any existing right or benefit provided under law or by contract.

(c) Nothing in this section shall be construed to require an individual or group disability insurance policy to cover experimental or investigational treatments.

(d) This section shall not apply to specified accident-only, specified disease, hospital indemnity, Medicare supplement, or long-term care health care insurance policies.

(e) The requirements of this section shall not apply to a group disability insurance policy purchased by an employer that is a religious organization or a controlled religious subsidiary of a religious organization, including a church, religious institution, religious association, or other religious organization that is not organized for private profit and that is exempt from registering and reporting regularly to the Registry of Charitable Trusts in the Office of the Attorney General, as defined by Section 12580 and following of the Government Code, if the provision of prescription contraceptive methods as

described in this section is inconsistent with the religious beliefs of the organization.

(f) Any insured employee whose family has a gross annual household income equal to or less than 400 percent of the federal poverty level, and his or her insured dependents, of an employer that elects not to provide coverage for prescription contraceptive methods as described in this section shall be eligible for a voucher, through the California State-Only Family Planning Program as established by Section 24000 of the Welfare and Institutions Code, for prescription contraceptive benefits as described in this section.

(g) On and after July 1, 1999, every disability insurer that contracts with an employer who meets the religious exemption provisions of subdivision (e), and who elects not to provide contraceptive coverage shall provide the following notice to all persons insured under that employer's group policy in a separate document or in the evidence of coverage, in at least 12-point type:

**"HEALTH INSURANCE CONTRACEPTIVE
COVERAGE**

(1) California law requires disability insurers to include FDA-approved contraceptive drugs and devices in pharmaceutical benefit packages.

(2) California law exempts religious organizations from providing insurance packages that include prescription contraceptive coverage.

(3) [The employer's name] is a religious organization or controlled religious subsidiary and has elected not to provide contraceptive coverage to its employees.

(4) California law provides that insured employees who have a gross annual household income equal to or less than 400 percent of the federal poverty, and their insured dependents, who work for an exempted religious organization or controlled religious subsidiary electing not to provide the prescription contraceptive benefit shall be eligible for a voucher for this benefit through the California State-Only Family Planning Program, as

authorized by Sections 24003 and 24007 of the Welfare and Institutions Code.

(5) If you are interested in this voucher for prescription contraceptive benefits, please contact the State Department of Health Services for more information. The Department's "Family PACT" program's toll-free number is: (800) 942-1054."

SEC. 4. Section 24003 of the Welfare and Institutions Code is amended to read:

24003. (a) A person shall be eligible to receive services pursuant to this chapter provided that the either conditions (1) to (4), inclusive, are met, or that condition (5) is met, as follows:

(1) The person is a resident of California.

(2) The person has a family income at or below 200 percent of the federal poverty level.

(3) The person has no other source of health care coverage unless the use of that health care coverage would create a barrier to access because of confidentiality.

(4) The person is not otherwise eligible for existing Medi-Cal services without a share of cost.

(5) The person is a covered employee, or a covered dependent of an employee, of an employer that is exempt from the requirement of providing a health care service plan contract or a disability insurance policy that includes coverage for prescription contraceptives pursuant to Section 1367.25 of the Health and Safety Code or Section 10123.196 of the Insurance Code and the employee's family has a gross annual household income equal to or less than 400 percent of the federal poverty level.

(b) Notwithstanding any other provision of law, the provision of family planning services shall not require the consent of anyone other than the person who is to receive the services.

(c) Eligibility shall be determined at point of service by the provider. The provider shall obtain information on the individual's family size, income, and health care coverage and then, based on that information, determine

if the individual meets the eligibility criteria specified in subdivision (a). All individuals who meet the eligibility requirements shall be certified by the provider as eligible for services under the program. A Medi-Cal share of cost shall not be used to deny access to family planning services under the program. The department may require the collection on a voluntary basis or the use of the individual's social security number, or both. No services shall be denied to a client if a social security number is not provided.

(d) Eligibility shall be based on the individual's self-declaration of gross annual or monthly income, family size, and other source of health care coverage, signed under penalty of perjury at each annual eligibility certification. No asset information shall be used to determine eligibility.

(e) The department may establish a copayment system for services provided pursuant to this chapter that is based upon the income level of the individual and the cost of the service provided. No individual whose documented family income is at or below 100 percent of the federal poverty level shall be subject to copayment. The copayment fee shall not be used to deny access to family planning services. State reimbursement to the provider shall be offset by that amount of the copayment collected from the eligible individual. The department shall notify providers on an annual basis of the copayment fee schedule.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act

AB 1112

— 10 —

shall become operative on the same date that the act takes effect pursuant to the California Constitution.

Gold, Rachel

From: Theresa Connor [tmconnor@email.msn.com]
Sent: Thursday, February 25, 1999 1:20 PM
To: Janet Crepps; Kathryn Kolbert; Terry Fromson; Rachel Gold
Subject: Washington Contraceptive Equity Bill and Religious Exemption

S-1614.2

SUBSTITUTE SENATE BILL 5512

State of Washington 56th Legislature 1999 Regular Session

By Senate Committee on Health & Long-Term Care (originally sponsored by Senators Costa, Winsley, Kline, Patterson, Gardner, Prentice, Long, Goings, Snyder, Fraser, Brown, Kohl-Welles, Jacobsen, Spanel, Fairley, Haugen, Wojahn, Thibaudeau, Loveland, Bauer, Eide, B. Sheldon, McAuliffe, T. Sheldon, Heavey and Shin)

Read first time 02/22/1999.

AN ACT Relating to contraceptive health care benefits; adding new sections to chapter 48.43 RCW; and creating a new section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. Sec. 1. The legislature finds that: (1) Over half of all pregnancies are unintended; (2) by reducing rates of unintended pregnancy, contraceptives help reduce the need for abortion; (3) unintended pregnancies lead to higher rates of infant mortality, low birth weight, and maternal morbidity, and threaten the economic viability of families; (4) contraceptive services are part of basic health care, allowing families to both adequately space desired pregnancies and avoid unintended pregnancy; (5) many health carriers cover prescription drugs and devices but exclude prescription contraceptives and contraceptive devices; (6) women of child-bearing age spend significantly more than men on out-of-pocket health care costs, with contraceptives and reproductive health care services accounting for most of this disparity; (7) lack of contraceptive coverage in health plans places many effective forms of contraceptives beyond the financial reach of many women, leading to unintended pregnancies; and (8) the ability to plan her childbearing is central to a woman's ability to participate on an equal basis in education and employment.

The legislature intends to reduce the number of unintended pregnancies and ensure access to contraceptive services in health plans that cover prescription drugs and outpatient health services. The legislature also intends to further the goal of eliminating sex discrimination in health benefits for women.

NEW SECTION. Sec. 2. A new section is added to chapter 48.43 RCW to read as follows:

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Prescription contraceptive drugs and devices" means prescription contraceptive drugs and devices approved by the federal food and drug administration, including oral contraceptives, intrauterine devices (IUDs), injectables, hormonal implants, diaphragms, cervical caps, and emergency contraception.

(b) "Outpatient contraceptive services" means services necessary for the effective use of contraception, including family planning consultations, examinations, procedures for inserting, removing, or dispensing prescription

contraceptive methods, and laboratory services provided on an outpatient basis and related to the use of contraceptive methods, including natural family planning.

(2) Health carriers shall not exclude or restrict an enrollee's access to:

(a) Prescription contraceptive drugs and devices approved by the federal food and drug administration if the enrollee's health plan provides benefits for prescription drugs; or

(b) Outpatient contraceptive services, if the enrollee's health plan provides benefits for outpatient health services.

(3) Except as provided in subsection (4) of this section, a health carrier shall not create or impose disincentives for utilization of the benefits required by subsection (2) of this section.

(4) Nothing in this section shall be construed as:

(a) Preventing a health carrier from imposing deductibles, coinsurance, other cost-sharing requirements, or other limitations in relation to providing prescription contraceptive drugs and devices, or outpatient contraceptive services, provided that such deductible, coinsurance, other cost-sharing requirement, or other limitation is not greater than or different from the deductible, coinsurance, other cost-sharing requirement, or other limitation for other prescription drugs, devices, or outpatient health care services covered under the plan;

(b) Requiring a health carrier to cover experimental or investigative prescription contraceptive drugs and devices, or outpatient contraceptive services, except to the extent that a plan provides coverage for other experimental or investigative prescription drugs, devices, or outpatient health care services; or

(c) Allowing a health carrier to limit a health care provider's ability to prescribe contraceptive drugs for medical purposes such as decreasing risk of ovarian cysts or eliminating symptoms of menopause.

(5) This section applies to health plans issued or renewed on or after the effective date of this section.

NEW SECTION. Sec. 3. A new section is added to chapter 48.43 RCW to read as follows:

(1) The legislature recognizes that every individual possesses a fundamental right to exercise their religious beliefs. The legislature further recognizes that in developing public policy, conflicting religious beliefs must be respected. Therefore, while recognizing the right of religious objection to participating in the provision of contraceptive health care services, the state shall also recognize the right of individuals to access the prescription contraceptive drugs and devices and outpatient contraceptive health care services required by this section and section 2 of this act.

(2)(a) No individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstances to participate in the provision of or payment for prescription contraceptive drugs and devices and outpatient contraceptive services if they object to doing so for reason of conscience or religion. No person may be discriminated against in employment or professional privileges because of such an objection.

(b) The provisions of (a) of this subsection are not intended to result in an enrollee being denied timely access to prescription contraceptive drugs and devices and outpatient contraceptive services.

(3)(a) Health carriers that are not religiously sponsored shall allow enrollees whose health care provider or plan-designated health care facility declines to participate in the provision of contraceptive health care services to use another health care provider or health care facility with whom the plan shall contract to ensure timely access to qualified providers within the local community.

(b) Each religiously sponsored health carrier that invokes the religious exemption provided under subsection (2)(a) of this section shall: (i) Provide written notice to enrollees upon enrollment with the plan, listing the contraceptive health services they refuse to cover for reason of conscience or religion; (ii) provide written information describing how an

enrollee may directly access prescription drugs and devices and outpatient contraceptive health care services in an expeditious manner; and (iii) ensure that enrollees refused services under this section have prompt access to the information developed under (b)(ii) of this subsection.

(4)(a) No individual or religious organization may be required to purchase coverage for contraceptive health care services if they object to doing so for reason of conscience or religion. The provision of this subsection shall not result in an enrollee being denied coverage of, and timely access to, prescription contraceptive drugs and devices and outpatient contraceptive services.

(b) Health carriers that are not religiously sponsored shall allow religious organizations opposed to contraceptive health services to refuse to pay for coverage of such benefits in a group plan. Health carriers shall allow enrollees in a health plan exempted under this subsection to directly purchase coverage of prescription drugs and devices and outpatient contraceptive services from the carrier. The enrollee's cost of purchasing such coverage shall not exceed the enrollee's pro rata share of the price the group purchaser would have paid for such coverage had the group plan not invoked a religious exemption.

(5) Nothing in this section requires a health carrier, health care facility, or health care provider to provide any health care services without appropriate payment of premium or fee.

NEW SECTION. Sec. 4. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

— END —SENATE BILL REPORT

SB 5512

As Reported By Senate Committee On:

Health & Long-Term Care, February 17, 1999

Title: An act relating to contraceptive health care benefits.

Brief Description: Requiring health plans that cover prescription drugs to cover the cost of prescription contraceptives.

Sponsors: Senators Costa, Winsley, Kline, Patterson, Gardner, Prentice, Long, Goings, Snyder, Fraser, Brown, Kohl-Welles, Jacobsen, Spanel, Fairley, Haugen, Wojahn, Thibaudeau, Loveland, Bauer, Eide, B. Sheldon, McAuliffe, T. Sheldon, Heavey and Shin.

Brief History:

Committee Activity: Health & Long-Term Care: 1/27/99, 2/17/99 [DPS].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 5512 be substituted therefor, and the substitute bill do pass.

Signed by Senators Thibaudeau, Chair; Wojahn, Vice Chair; Costa, Franklin, Winsley.

Staff: Jonathan Seib (786-7427)

Background: In response to concerns about inequity, and the economic and social impact of some health insurance plans' failure to provide contraceptive benefits, legislation was introduced in 1998 requiring plans to provide such benefits. The legislation was referred to the Department of Health for review under the mandated health benefits review process set forth in statute.

The Department of Health issued its final report in January 1999. The report analyzes the efficacy of the mandate, and its social and financial

impact, and concludes that "[t]he Legislature should enact legislation mandating contraceptive services for all state regulated health plans."

Also in 1998, the Office of the Insurance Commissioner (OIC) conducted a survey to determine the level of reproductive health benefit coverage in health insurance plans marketed in Washington. Among the OIC findings was that 50 percent of the plans cover contraceptive services in some form, and that 30 percent of all plans and 22 percent of eligible enrollees have "core" contraceptive coverage.

Summary of Substitute Bill: A health plan issued to individuals or groups may not restrict an enrollee's access to prescription contraceptive drugs and devices if the plan otherwise provides benefits for prescription drugs, or to outpatient contraceptive services if the plan otherwise provides benefits for outpatient health services. The terms and conditions of coverage for contraceptives must be the same as the terms and conditions of coverage for other prescription drugs, devices, or outpatient health care services covered under the plan.

Subject to certain requirements, no individual health care provider, religiously sponsored health carrier, or health care facility may be required to participate in the provision of or payment for contraceptives if they object to doing so for reason of conscience or religion. No individual or religious organization may be required to purchase coverage for contraceptives if they object to doing so for reason of conscience or religion. However, insurance enrollees from a religious organization wishing to purchase contraceptive coverage may do so directly through the insurance carrier.

Substitute Bill Compared to Original Bill: Language is added in the proposed substitute providing an exemption from the bill for those who object to contraceptives for reason of conscience or religion.

Appropriation: None.

Fiscal Note: Available.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Testimony For: Contraceptive coverage is the good and cost effective thing to do. Absent a mandate, carriers have not demonstrated a willingness to provide contraceptive coverage. This bill represents the right to equal insurance for men and women. Some women need contraceptives for health reasons, and have not had access to them. Unintended pregnancy imposes social and economic costs on all segments of society. This bill would increase access to contraceptives as a way to address this problem.

Testimony Against: Mandating any health insurance benefit increases insurance costs and decreases choices in an already volatile insurance market. A contraceptive mandate sends the wrong message to teenagers and will interfere with the parent/child relationship. Most contraceptives are abortifacients and can be harmful to a persons' health. The bill would force those who object to contraceptives to help pay for them for others.

Testified: Steve Boruchowitz, Department of Health; **PRO:** Lori Bielinski, Office of the Insurance Commissioner; Heather Jones Sin; Lynn Frink; Jesse Wing, ACLU; Judy Turpin, Northwest Women's Law Center; Melinda Percica, Washington State Council on Family Planning; Joe Mancuso, M.D. ACOG; **CON:** Priscilla Martens, Washington Evangelicals for Responsible Government; Jeff Kemp, Washington Family Council; Robin Bernhoft, National Parent's Council; Jim Halstrom, Health Care Purchasers Association, Association of Washington Business; **CONCERNS:** Eric Paige, Washington State Catholic Conference.

To Senate Bill No. 400 File No. 545 Cal No. 148

<http://www.cga.state>HOME | SEARCH

STATE OF CONNECTICUT

AMENDMENT

LCO No. 4250

General Assembly

February Session, A.D., 1998

Offered by SEN. JEPSEN, 27th DIST.

SEN. DELUCA, 32nd DIST.

SEN. BOZEK, 6th DIST.

To Senate Bill No. 400

File No. 545

Cal No. 148

Entitled: "AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR
PRESCRIPTION BIRTH CONTROL."

In line 1, after "(NEW)" insert "(a)"

After line 12 insert the following:

"(b) Notwithstanding any other provision of this section, any insurance company, hospital or medical service corporation, or health care center may issue to a religious employer an individual health insurance policy that excludes coverage for prescription contraceptive methods which are contrary to the religious employer's bona fide religious tenets.

(c) Any health insurance policy issued pursuant to subsection (b) of this section shall provide written notice to each insured or prospective insured that prescription contraceptive methods are ~~excluded from~~ coverage pursuant to said subsection. Such notice shall appear, in not less than ten point type, in the policy, application and sales brochure for such policy.

(d) Nothing in this section shall be construed as authorizing an individual health insurance policy to exclude coverage for prescription drugs ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes.

(e) Notwithstanding any other provision of this section, any insurance company, hospital or medical service corporation, or health care center which is owned, operated or substantially controlled by a religious organization which has religious or moral tenets which conflict with the requirements of this act may provide for the coverage of prescription contraceptive methods as required under this section through another such entity offering a limited benefit plan. The cost, terms and availability of such coverage shall not differ from the cost, terms and availability of other prescription coverage offered to the insured.

(f) As used in this section, "religious employer" means an employer that is a "qualified church-controlled organization" as defined in 26 USC 3121."

In line 13, after "(NEW)" insert "(a)"

After line 23 add the following:

"(b) Notwithstanding any other provision of this section, any insurance company, hospital or medical service corporation, or health care center may issue to a religious employer a group health insurance policy that excludes coverage for prescription contraceptive methods which are contrary to the religious employer's bona fide religious tenets.

(c) Any health insurance policy issued pursuant to subsection (b) of this section shall provide written notice to each insured or prospective insured that prescription contraceptive methods are excluded from coverage pursuant to said subsection. Such notice shall appear, in not less than ten point type, in the policy, application and sales brochure for such policy.

(d) Nothing in this section shall be construed as authorizing

a group health insurance policy to exclude coverage for prescription drugs ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes.

(e) Notwithstanding any other provision of this section, any insurance company, hospital or medical service corporation, or health care center which is owned, operated or substantially controlled by a religious organization which has religious or moral tenets which conflict with the requirements of this act may provide for the coverage of prescription contraceptive methods as required under this section through another such entity offering a limited benefit plan. The cost, terms and availability of such coverage shall not differ from the cost, terms and availability of other prescription coverage offered to the insured.

(f) As used in this section, "religious employer" means an employer that is a "qualified church-controlled organization" as defined in 26 USC 3121."

TOP

MEMORANDUM

Date: 4/27/99

To: Chris, Elena, and Sarah

From: Jenny

Re: Conscience clause options – a starting point.

I've attached three different conscience clause provisions from bills that are being considered by state legislatures. Viable language would probably need to address the concerns of religious employers, health care plans, and individual medical providers. None of the provisions described below address all of these but they help to convey a sense of what such language might begin to look like.

I've also attached a helpful overview by the Allen Guttmacher Institute (AGI).

1. California

Religious employers may opt out but employees earning below a certain income level that work for such employers may obtain contraceptives through the state-funded family planning program. (Bill was vetoed by Gov. Wilson last year.)

2. Washington State

Religious employers can opt out but their employees can purchase contraceptive coverage directly from the employers' plan at a group rate.

3. Connecticut

Religious-based plans can opt out as long as contraceptive coverage is provided through another entity offering a limited benefit plan.

In addition, there are examples of religious-based plans adapting to contraceptive coverage requirements in both the Medicaid and private markets. According to AGI, a religious plan has contracted with an outside agency to administer the family planning benefits for its Medicaid enrollees. Another religious plan successfully bid on a private employer contract that required contraceptive coverage. The premiums go to an intermediary which divides the funds between the religious plan and a separate insurer that covers contraception, abortion and sterilization services. It would be helpful to have more information about how religious plans have addressed other health care services that go against their beliefs, such as sterilization.

Latest news is that bill may be dropped next week.

Issues & Implications

Contraceptive Coverage: Toward Ensuring Access While Respecting Conscience

By Rachel Benson Gold

Recent high-profile confrontations over requiring coverage of contraceptive services in insurance plans have raised long-standing, thorny "conscience" issues, albeit in a new context. But whether the debate is over coverage for federal employees or coverage for all private-sector employees, the central questions remain the same: What individuals or entities should be entitled to claim a conscientious objection to contraceptive coverage on what grounds, and how can the deleterious impact of those objections on individuals needing and entitled to services be minimized?

Government as Employer

This fall, the federal government took the crucial step of guaranteeing contraceptive coverage for its own employees in the largest employer-sponsored insurance program in the world, the Federal Employees Health Benefits Program (FEHBP). Clearly, grappling with the question of conscience was key to allowing the proposal to become a reality for the nine million enrollees in the program (see *For the Record*, page 12.)

As ultimately played out in the FEHBP debate, the conscience issue had two distinct aspects—the first regarding health plans that sign contracts as corporate entities with the Office of Personnel Management (OPM), the federal agency administering the insurance program, and the second regarding individual health care providers operating within those plans.

The first issue was by far the more contentious. Opponents of contra-

ceptive coverage argued for the widest possible conscience exemption—one that would allow any plan to decline to provide the coverage because of a "moral" objection to doing so. In order to guarantee access to the greatest number of enrollees, contraceptive coverage supporters pressed for the narrowest possible exemption—one that would permit only clearly religious plans to opt out of coverage. In the end, supporters prevailed; the final language allows an exemption only for plans that object to contraception "on the basis of religious beliefs."

As for individual health care providers operating within plans, the provision as enacted codifies the widely accepted standard that individual practitioners may decline to provide specific medical services if doing so would be contrary to their religious beliefs or "moral convictions."

Private Sector Challenges

As difficult as these questions were in the debate over the FEHBP, they become even more complex when the issue is not the federal government imposing a mandate on itself as

Models in both public policy and private-sector action indicate that the problems are not unsolvable.

an employer but, rather, federal or state policymakers imposing a mandate on private-sector coverage in general. Here, the balance between the perceived need to exempt some individuals and institutions from cov-

ering or providing contraceptive services on conscience grounds and the right of individual employees to obtain the coverage or care to which they are entitled is a tricky one. Given the specific players involved, it may be more or less difficult to achieve. Fortunately, there are sufficient models—in both public policy and private-sector action—to indicate that the problems are not unsolvable.

When Providers Opt Out

The question of an individual health care provider declining to provide a specific service does not pose an overwhelming obstacle to a patient's care in traditional fee-for-service plans in which the choice of provider is essentially unrestricted. However, when the context is a managed care plan, in which enrollees are limited to a specified network of providers, allowing individual providers to opt out raises more difficult issues.

The extent to which this is problematic may be eased somewhat by the long-standing and well-recognized obligation of managed care plans to make covered services accessible to enrollees. As articulated most recently by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry in its Patient Bill of Rights, this includes the obligation of the plan to ensure that adequate providers are available for all covered services: "All health plan networks should provide access to sufficient numbers and types of providers to assure that all covered services will be accessible without delay....If a health plan has an insufficient number or type of providers to provide a covered benefit with the appropriate degree of specialization, the plan should ensure that the consumer obtains the benefit outside the network at no greater cost than if the benefit were obtained from participating providers."

Indeed, this standard was reiterated by OPM in implementing the mandate for federal employees' coverage. OPM directed federal agencies to inform their employees that if an individual provider within a plan declines to provide contraception, they should contact the plan, which "will arrange for you to have access to a provider who will...."

When Employers Opt Out

The question of employers who may object to contraceptive coverage for their employees adds yet another dimension to an already complex situation. This question was moot in the FEHBP debate, where the employer—the federal government—clearly does not have a religious objection to contraception. In the general private sector, however, it is more difficult.

Here, as in the case with FEHBP plans, the goal should be crafting an exemption as narrowly as possible. This is because in the private sector, it is largely employers who choose

When a religious employer objects to contraceptive coverage, it does so for all its employees—many of whom may not share the employer's beliefs.

their employees' insurance plans. For example, when a large religious university—in its role as employer—claims a conscientious objection to contraception, it is making that choice for all of its employees, many of whom may have no affiliation whatsoever with the employer's religious beliefs.

The scope of an exemption for employers was very much at issue in the 12 states in which contraceptive coverage was seriously considered this year, including Maryland, where a measure was actually enacted, and California, where a measure passed

by both houses of the legislature was vetoed by the governor. All told, most of the states considering legislation chose to limit the exemption to religious employers, either "qualified church-controlled organizations" as defined by the U.S. tax code or, more generally, employers for whom covering contraception would conflict with "bona fide" religious tenets.

Thus far, California is the only state whose legislature has taken specific action designed to prevent individual employees from being disadvantaged as a result of a conscientious objection being invoked by their employer. As passed, the California contraceptive coverage mandate made employees whose employers objected to contraceptive coverage eligible for state-funded coverage, as part of a larger state-funded family planning program.

The California measure required that the employees in such situations be notified that their employer is a religious organization that has elected not to provide contraceptive coverage in its plan, and that they may be eligible to obtain services through the special state-funded program. The legislation went so far as to require that these employees be given the toll-free phone number for the state's family planning program.

While the California bill ultimately fell victim to the governor's veto pen (see *For The Record*, page 12), it stands as an important model for attempts to strike a balance between maintaining the ability of employers to adhere to religious doctrine in opposition to contraception and protecting the right of employees and their dependents not to be hurt as a result of their employers choosing to do so.

When Plans Opt Out

Finally, in the general private sector, the question of allowing plans to claim an exemption raises the question of how a religious plan that

objects to providing contraception can survive in a marketplace in which most employers are required to provide contraceptive coverage. In fact, numerous religious plans across the country have already been able to quietly craft their own solution in roughly analogous situations, allowing them to either participate in Medicaid programs that require coverage of contraception or compete in the private marketplace when contraceptive coverage is demanded by those seeking coverage. These solutions effectively keep the religious plan at sufficient arm's length from the actual provision of services to which they may object on religious grounds.

For example, a religious plan in the Southwest recently contracted with an outside agency to administer the family planning benefits for its Medicaid enrollees. (Under Medicaid, family planning is a mandated service to which enrollees are legally entitled.) The plan gives a portion of its Medicaid capitation payment to the outside agency, which in turn reimburses providers for the family planning services provided to enrollees. Individual providers within the plan sign independent contracts with this outside agency for family planning services only, and are reimbursed directly by it on a fee-for-service basis. Enrollees obtain care from their own plan providers, making the transition seamless from the enrollees' perspective.

In a letter to providers, the plan explained the balance it was seeking to strike, saying it "does not endorse these services nor are you required to provide them. However, these services must be available to our members."

Similarly, a Catholic-sponsored health plan in the Midwest has crafted an arrangement in a private-sector contract. Here, the plan sought to bid on a contract from a large corporation that required cov-

(Continued on page 14)

Issues & Implications**Contraceptive Coverage...***Continued from page 2*

erage of a range of reproductive health care services in its policy. To allow it to secure the contract, the plan arranged for the premiums to go first to an intermediary, which divides the funds between the plan and a separate insurer that has agreed to cover the contraception, abortion and sterilization services that the religious plan will not. To obtain these services, enrollees go to the providers listed in the plan's provider directory, and the charges for these services are billed to the separate insurer.

Both of these models allow religious plans to participate in a market where coverage of contraceptive services is required while distancing themselves somewhat from the provision of those services.

Contraceptive coverage language considered this year in Connecticut included such a "black box" option. The measure—which passed the Senate but stalled in the House—would have allowed a religious plan "to provide coverage of contracep-

Both in the context of Medicaid and the private market, religious plans have found ways to provide access to contraceptives while remaining "at arm's length" from them.

tive methods through another such entity offering a limited benefit plan; the cost, terms and availability of such coverage may not differ from that of other prescription coverage offered to the insured."

In short, the contraceptive coverage issue highlights a number of fault lines at the intersection of religious beliefs and the provision of health care services. As Congress and state legislatures continue to consider private-sector contraceptive coverage mandates, however, they should be aware that for each of the difficult issues that have been raised, creative thinking has pointed the way to at least the beginnings of some tenable options.

This is the third in a special series of articles examining key policy questions raised by the effort to require coverage of contraceptive services and supplies in private-sector insurance plans. These analyses are supported in part by a grant from the Prospect Hill Foundation. The conclusions and opinions expressed in them are those of the author and The Alan Guttmacher Institute and do not necessarily represent the views of the foundation. ®

THE GUTTMACHER REPORT

ON PUBLIC POLICY

December 1998

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PERMIT No. 588

CA Assembly Bill No. 1112

Passed the Assembly August 26, 1998

Chief Clerk of the Assembly

Passed the Senate August 12, 1998

Secretary of the Senate

This bill was received by the Governor this ____ day
of _____, 1998, at ____ o'clock ____

Private Secretary of the Governor

CHAPTER _____

An act to add Section 1367.25 to the Health and Safety Code, to add Section 10123.196 to the Insurance Code, and to amend Section 24003 of the Welfare and Institutions Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1112, Hertzberg. Health care coverage.

(1) Existing law provides for the licensure and regulation of health care service plans administered by the Commissioner of Corporations. Under existing law, a willful violation of any of these provisions is punishable as either a felony or a misdemeanor. Existing law also provides for the regulation of policies of disability insurance by the Insurance Commissioner.

Existing law requires that health care service plans and disability insurers provide coverage for certain benefits and services.

This bill would require certain group health care service plan contracts and certain group disability insurance policies, issued, amended, renewed, or delivered on or after January 1, 1999, and certain individual health care service plan contracts and certain individual policies of disability insurance of a type and form first offered for sale on and after January 1, 1999, to provide coverage, under terms and conditions applicable to other benefits, for a variety of federal Food and Drug Administration approved prescription contraceptive methods. This bill would exempt insurance policies or health care service plans provided by certain religious organizations, and their controlled religious subsidiaries, from this requirement. The bill would require, on and after July 1, 1999, these health care service plans and disability insurers to provide employees of these exempt employers with notice that contraceptive drugs and devices are available through the California State-Only Family Planning Program, for employees whose family has a gross annual household income equal to or less than

400% of the federal poverty level. The bill would require that program to make those benefits available to those people.

By changing the definition of the crime applicable to health care service plans, this bill would impose a state-mandated local program.

(2) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known and may be cited as the Women's Contraception Equity Act.

SEC. 2. Section 1367.25 is added to the Health and Safety Code, to read:

1367.25. (a) Every group health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 1999, and every individual health care service plan contract of a type and form first offered for sale on or after January 1, 1999, except for a specialized health care service plan contract, shall provide coverage for the following, under general terms and conditions applicable to all benefits:

(1) A health care service plan contract that provides coverage for outpatient prescription drug benefits shall include coverage for a variety of federal Food and Drug Administration approved prescription contraceptive methods, designated by the plan. In the event the patient's provider, acting within his or her scope of practice, determines that none of the methods designated by the plan is medically appropriate for the patient, the plan shall also provide coverage for another federal Food and Drug Administration approved, medically appropriate prescription contraceptive method prescribed by the patient's provider.

(2) Outpatient prescription benefits for an enrollee shall be the same for an enrollee's covered spouse and covered nonspouse dependents.

(b) Nothing in this section shall be construed to deny or restrict in any way any existing right or benefit provided under law or by contract.

(c) Nothing in this section shall be construed to require an individual or group health care service plan to cover experimental or investigational treatments.

→ (d) The requirements of this section shall not apply to a group health care service plan contract purchased by an employer that is a religious organization or a controlled religious subsidiary of a religious organization, including a church, religious institution, religious association, or other religious organization that is not organized for private profit and that is exempt from registering and reporting regularly to the Registry of Charitable Trusts in the Office of the Attorney General, as defined by Section 12580 and following of the Government Code, if the provision of prescription contraceptive methods as described in this section is inconsistent with the religious beliefs of the organization.

→ (e) Any enrolled employee whose family has a gross annual household income equal to or less than 400 percent of the federal poverty level, and his or her enrolled dependents, of an employer that elects not to provide coverage for prescription contraceptive methods as described in this section shall be eligible for a voucher, through the California State-Only Family Planning Program as established by Section 24000 of the Welfare and Institutions Code, for prescription contraceptive benefits as described in this section.

(f) On and after July 1, 1999, every health care service plan that contracts with an employer who meets the religious exemption provisions of subdivision (d) and who elects not to provide contraceptive coverage shall provide the following notice to all subscribers under that employer's group contract in a separate document or in the plan evidence of coverage, in at least 12-point type:

"HEALTH PLAN CONTRACEPTIVE COVERAGE

(1) California law requires health care service plans to include FDA-approved contraceptive drugs and devices in pharmaceutical benefit packages.

(2) California law exempts religious organizations from providing health benefit plans that include prescription contraceptive coverage.

(3) [The employer's name] is a religious organization or a controlled religious subsidiary and has elected not to provide contraceptive coverage to its employees.

(4) California law provides that covered employees who have a gross annual household income equal to or less than 400 percent of the federal poverty level, and their covered dependents, who work for an exempted religious organization or a controlled religious subsidiary electing not to provide the prescription contraceptive benefit shall be eligible for a voucher for this benefit through the California State-Only Family Planning Program, as authorized by Sections 24003 and 24007 of the Welfare and Institutions Code.

(5) If you are interested in this voucher for prescription contraceptive benefits, please contact the State Department of Health Services for more information. The department's "Family PACT" program's toll-free number is: (800) 942-1054."

SEC. 3. Section 10123.196 is added to the Insurance Code, immediately following Section 10123.195, to read:

10123.196. (a) Every group policy of disability insurance that covers hospital, medical, or surgical expenses, and that is issued, amended, renewed, or delivered on or after January 1, 1999, and every individual policy of disability insurance that covers hospital, medical, and surgical expenses and that is of a type and form first offered for sale on or after January 1, 1999, shall

provide coverage for the following, under general terms and conditions applicable to all benefits:

(1) A disability insurance policy that provides coverage for outpatient prescription drug benefits shall include coverage for a variety of federal Food and Drug Administration approved prescription contraceptive methods, designated by the insurer. In the event the patient's provider, acting within his or her scope of practice, determines that none of the methods designated by the insurer is medically appropriate for the patient, the insurer shall also provide coverage for another federal Food and Drug Administration approved, medically appropriate prescription contraceptive method prescribed by the patient's provider.

(2) Outpatient prescription benefits for an insured shall be the same for an insured's covered spouse and covered nonspouse dependents.

(b) Nothing in this section shall be construed to deny or restrict in any way any existing right or benefit provided under law or by contract.

(c) Nothing in this section shall be construed to require an individual or group disability insurance policy to cover experimental or investigational treatments.

(d) This section shall not apply to specified accident-only, specified disease, hospital indemnity, Medicare supplement, or long-term care health care insurance policies.

(e) The requirements of this section shall not apply to a group disability insurance policy purchased by an employer that is a religious organization or a controlled religious subsidiary of a religious organization, including a church, religious institution, religious association, or other religious organization that is not organized for private profit and that is exempt from registering and reporting regularly to the Registry of Charitable Trusts in the Office of the Attorney General, as defined by Section 12580 and following of the Government Code, if the provision of prescription contraceptive methods as

described in this section is inconsistent with the religious beliefs of the organization.

(f) Any insured employee whose family has a gross annual household income equal to or less than 400 percent of the federal poverty level, and his or her insured dependents, of an employer that elects not to provide coverage for prescription contraceptive methods as described in this section shall be eligible for a voucher, through the California State-Only Family Planning Program as established by Section 24000 of the Welfare and Institutions Code, for prescription contraceptive benefits as described in this section.

(g) On and after July 1, 1999, every disability insurer that contracts with an employer who meets the religious exemption provisions of subdivision (e), and who elects not to provide contraceptive coverage shall provide the following notice to all persons insured under that employer's group policy in a separate document or in the evidence of coverage, in at least 12-point type:

"HEALTH INSURANCE CONTRACEPTIVE COVERAGE

(1) California law requires disability insurers to include FDA-approved contraceptive drugs and devices in pharmaceutical benefit packages.

(2) California law exempts religious organizations from providing insurance packages that include prescription contraceptive coverage.

(3) [The employer's name] is a religious organization or controlled religious subsidiary and has elected not to provide contraceptive coverage to its employees.

(4) California law provides that insured employees who have a gross annual household income equal to or less than 400 percent of the federal poverty, and their insured dependents, who work for an exempted religious organization or controlled religious subsidiary electing not to provide the prescription contraceptive benefit shall be eligible for a voucher for this benefit through the California State-Only Family Planning Program, as

authorized by Sections 24003 and 24007 of the Welfare and Institutions Code.

(5) If you are interested in this voucher for prescription contraceptive benefits, please contact the State Department of Health Services for more information. The Department's "Family PACT" program's toll-free number is: (800) 942-1054."

SEC. 4. Section 24003 of the Welfare and Institutions Code is amended to read:

24003. (a) A person shall be eligible to receive services pursuant to this chapter provided that the either conditions (1) to (4), inclusive, are met, or that condition (5) is met, as follows:

(1) The person is a resident of California.

(2) The person has a family income at or below 200 percent of the federal poverty level.

(3) The person has no other source of health care coverage unless the use of that health care coverage would create a barrier to access because of confidentiality.

(4) The person is not otherwise eligible for existing Medi-Cal services without a share of cost.

(5) The person is a covered employee, or a covered dependent of an employee, of an employer that is exempt from the requirement of providing a health care service plan contract or a disability insurance policy that includes coverage for prescription contraceptives pursuant to Section 1367.25 of the Health and Safety Code or Section 10123.196 of the Insurance Code and the employee's family has a gross annual household income equal to or less than 400 percent of the federal poverty level.

(b) Notwithstanding any other provision of law, the provision of family planning services shall not require the consent of anyone other than the person who is to receive the services.

(c) Eligibility shall be determined at point of service by the provider. The provider shall obtain information on the individual's family size, income, and health care coverage and then, based on that information, determine

if the individual meets the eligibility criteria specified in subdivision (a). All individuals who meet the eligibility requirements shall be certified by the provider as eligible for services under the program. A Medi-Cal share of cost shall not be used to deny access to family planning services under the program. The department may require the collection on a voluntary basis or the use of the individual's social security number, or both. No services shall be denied to a client if a social security number is not provided.

(d) Eligibility shall be based on the individual's self-declaration of gross annual or monthly income, family size, and other source of health care coverage, signed under penalty of perjury at each annual eligibility certification. No asset information shall be used to determine eligibility.

(e) The department may establish a copayment system for services provided pursuant to this chapter that is based upon the income level of the individual and the cost of the service provided. No individual whose documented family income is at or below 100 percent of the federal poverty level shall be subject to copayment. The copayment fee shall not be used to deny access to family planning services. State reimbursement to the provider shall be offset by that amount of the copayment collected from the eligible individual. The department shall notify providers on an annual basis of the copayment fee schedule.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act

AB 1112

— 10 —

shall become operative on the same date that the act
takes effect pursuant to the California Constitution.

Gold, Rachel

From: Theresa Connor [tmconnor@email.msn.com]
Sent: Thursday, February 25, 1999 1:20 PM
To: Janet Crepps; Kathryn Kolbert; Terry Fromson; Rachel Gold
Subject: Washington Contraceptive Equity Bill and Religious Exemption

S-1614.2

SUBSTITUTE SENATE BILL 5512

State of Washington 56th Legislature 1999 Regular Session

By Senate Committee on Health & Long-Term Care (originally sponsored by Senators Costa, Winsley, Kline, Patterson, Gardner, Prentice, Long, Goings, Snyder, Fraser, Brown, Kohl-Welles, Jacobsen, Spanel, Fairley, Haugen, Wojahn, Thibaudeau, Loveland, Bauer, Eide, B. Sheldon, McAuliffe, T. Sheldon, Heavey and Shin)

Read first time 02/22/1999.

AN ACT Relating to contraceptive health care benefits; adding new sections to chapter 48.43 RCW; and creating a new section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. Sec. 1. The legislature finds that: (1) Over half of all pregnancies are unintended; (2) by reducing rates of unintended pregnancy, contraceptives help reduce the need for abortion; (3) unintended pregnancies lead to higher rates of infant mortality, low birth weight, and maternal morbidity, and threaten the economic viability of families; (4) contraceptive services are part of basic health care, allowing families to both adequately space desired pregnancies and avoid unintended pregnancy; (5) many health carriers cover prescription drugs and devices but exclude prescription contraceptives and contraceptive devices; (6) women of child-bearing age spend significantly more than men on out-of-pocket health care costs, with contraceptives and reproductive health care services accounting for most of this disparity; (7) lack of contraceptive coverage in health plans places many effective forms of contraceptives beyond the financial reach of many women, leading to unintended pregnancies; and (8) the ability to plan her childbearing is central to a woman's ability to participate on an equal basis in education and employment.

The legislature intends to reduce the number of unintended pregnancies and ensure access to contraceptive services in health plans that cover prescription drugs and outpatient health services. The legislature also intends to further the goal of eliminating sex discrimination in health benefits for women.

NEW SECTION. Sec. 2. A new section is added to chapter 48.43 RCW to read as follows:

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Prescription contraceptive drugs and devices" means prescription contraceptive drugs and devices approved by the federal food and drug administration, including oral contraceptives, intrauterine devices (IUDs), injectables, hormonal implants, diaphragms, cervical caps, and emergency contraception.

(b) "Outpatient contraceptive services" means services necessary for the effective use of contraception, including family planning consultations, examinations, procedures for inserting, removing, or dispensing prescription

contraceptive methods, and laboratory services provided on an outpatient basis and related to the use of contraceptive methods, including natural family planning.

(2) Health carriers shall not exclude or restrict an enrollee's access to:

(a) Prescription contraceptive drugs and devices approved by the federal food and drug administration if the enrollee's health plan provides benefits for prescription drugs; or

(b) Outpatient contraceptive services, if the enrollee's health plan provides benefits for outpatient health services.

(3) Except as provided in subsection (4) of this section, a health carrier shall not create or impose disincentives for utilization of the benefits required by subsection (2) of this section.

(4) Nothing in this section shall be construed as:

(a) Preventing a health carrier from imposing deductibles, coinsurance, other cost-sharing requirements, or other limitations in relation to providing prescription contraceptive drugs and devices, or outpatient contraceptive services, provided that such deductible, coinsurance, other cost-sharing requirement, or other limitation is not greater than or different from the deductible, coinsurance, other cost-sharing requirement, or other limitation for other prescription drugs, devices, or outpatient health care services covered under the plan;

(b) Requiring a health carrier to cover experimental or investigative prescription contraceptive drugs and devices, or outpatient contraceptive services, except to the extent that a plan provides coverage for other experimental or investigative prescription drugs, devices, or outpatient health care services; or

(c) Allowing a health carrier to limit a health care provider's ability to prescribe contraceptive drugs for medical purposes such as decreasing risk of ovarian cysts or eliminating symptoms of menopause.

(5) This section applies to health plans issued or renewed on or after the effective date of this section.

NEW SECTION. Sec. 3. A new section is added to chapter 48.43 RCW to read as follows:

(1) The legislature recognizes that every individual possesses a fundamental right to exercise their religious beliefs. The legislature further recognizes that in developing public policy, conflicting religious beliefs must be respected. Therefore, while recognizing the right of religious objection to participating in the provision of contraceptive health care services, the state shall also recognize the right of individuals to access the prescription contraceptive drugs and devices and outpatient contraceptive health care services required by this section and section 2 of this act.

(2)(a) No individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstances to participate in the provision of or payment for prescription contraceptive drugs and devices and outpatient contraceptive services if they object to doing so for reason of conscience or religion. No person may be discriminated against in employment or professional privileges because of such an objection.

(b) The provisions of (a) of this subsection are not intended to result in an enrollee being denied timely access to prescription contraceptive drugs and devices and outpatient contraceptive services.

(3)(a) Health carriers that are not religiously sponsored shall allow enrollees whose health care provider or plan-designated health care facility declines to participate in the provision of contraceptive health care services to use another health care provider or health care facility with whom the plan shall contract to ensure timely access to qualified providers within the local community.

(b) Each religiously sponsored health carrier that invokes the religious exemption provided under subsection (2)(a) of this section shall: (i) Provide written notice to enrollees upon enrollment with the plan, listing the contraceptive health services they refuse to cover for reason of conscience or religion; (ii) provide written information describing how an

enrollee may directly access prescription drugs and devices and outpatient contraceptive health care services in an expeditious manner; and (iii) ensure that enrollees refused services under this section have prompt access to the information developed under (b)(ii) of this subsection.

(4)(a) No individual or religious organization may be required to purchase coverage for contraceptive health care services if they object to doing so for reason of conscience or religion. The provision of this subsection shall not result in an enrollee being denied coverage of, and timely access to, prescription contraceptive drugs and devices and outpatient contraceptive services.

(b) Health carriers that are not religiously sponsored shall allow religious organizations opposed to contraceptive health services to refuse to pay for coverage of such benefits in a group plan. Health carriers shall allow enrollees in a health plan exempted under this subsection to directly purchase coverage of prescription drugs and devices and outpatient contraceptive services from the carrier. The enrollee's cost of purchasing such coverage shall not exceed the enrollee's pro rata share of the price the group purchaser would have paid for such coverage had the group plan not invoked a religious exemption.

(5) Nothing in this section requires a health carrier, health care facility, or health care provider to provide any health care services without appropriate payment of premium or fee.

NEW SECTION. Sec. 4. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

— END —SENATE BILL REPORT

SB 5512

As Reported By Senate Committee On:
Health & Long-Term Care, February 17, 1999

Title: An act relating to contraceptive health care benefits.

Brief Description: Requiring health plans that cover prescription drugs to cover the cost of prescription contraceptives.

Sponsors: Senators Costa, Winsley, Kline, Patterson, Gardner, Prentice, Long, Goings, Snyder, Fraser, Brown, Kohl-Welles, Jacobsen, Spanel, Fairley, Haugen, Wojahn, Thibaudeau, Loveland, Bauer, Eide, B. Sheldon, McAuliffe, T. Sheldon, Heavey and Shin.

Brief History:

Committee Activity: Health & Long-Term Care: 1/27/99, 2/17/99 [DPS].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 5512 be substituted therefor, and the substitute bill do pass.

Signed by Senators Thibaudeau, Chair; Wojahn, Vice Chair; Costa, Franklin, Winsley.

Staff: Jonathan Seib (786-7427)

Background: In response to concerns about inequity, and the economic and social impact of some health insurance plans' failure to provide contraceptive benefits, legislation was introduced in 1998 requiring plans to provide such benefits. The legislation was referred to the Department of Health for review under the mandated health benefits review process set forth in statute.

The Department of Health issued its final report in January 1999. The report analyzes the efficacy of the mandate, and its social and financial

impact, and concludes that "[t]he Legislature should enact legislation mandating contraceptive services for all state regulated health plans."

Also in 1998, the Office of the Insurance Commissioner (OIC) conducted a survey to determine the level of reproductive health benefit coverage in health insurance plans marketed in Washington. Among the OIC findings was that 50 percent of the plans cover contraceptive services in some form, and that 30 percent of all plans and 22 percent of eligible enrollees have "core" contraceptive coverage.

Summary of Substitute Bill: A health plan issued to individuals or groups may not restrict an enrollee's access to prescription contraceptive drugs and devices if the plan otherwise provides benefits for prescription drugs, or to outpatient contraceptive services if the plan otherwise provides benefits for outpatient health services. The terms and conditions of coverage for contraceptives must be the same as the terms and conditions of coverage for other prescription drugs, devices, or outpatient health care services covered under the plan.

Subject to certain requirements, no individual health care provider, religiously sponsored health carrier, or health care facility may be required to participate in the provision of or payment for contraceptives if they object to doing so for reason of conscience or religion. No individual or religious organization may be required to purchase coverage for contraceptives if they object to doing so for reason of conscience or religion. However, insurance enrollees from a religious organization wishing to purchase contraceptive coverage may do so directly through the insurance carrier.

Substitute Bill Compared to Original Bill: Language is added in the proposed substitute providing an exemption from the bill for those who object to contraceptives for reason of conscience or religion.

Appropriation: None.

Fiscal Note: Available.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Testimony For: Contraceptive coverage is the good and cost effective thing to do. Absent a mandate, carriers have not demonstrated a willingness to provide contraceptive coverage. This bill represents the right to equal insurance for men and women. Some women need contraceptives for health reasons, and have not had access to them. Unintended pregnancy imposes social and economic costs on all segments of society. This bill would increase access to contraceptives as a way to address this problem.

Testimony Against: Mandating any health insurance benefit increases insurance costs and decreases choices in an already volatile insurance market. A contraceptive mandate sends the wrong message to teenagers and will interfere with the parent/child relationship. Most contraceptives are abortifacients and can be harmful to a persons' health. The bill would force those who object to contraceptives to help pay for them for others.

Testified: Steve Boruchowitz, Department of Health; **PRO:** Lori Bielinski, Office of the Insurance Commissioner; Heather Jones Sin; Lynn Frink; Jesse Wing, ACLU; Judy Turpin, Northwest Women's Law Center; Melinda Percica, Washington State Council on Family Planning; Joe Mancuso, M.D. ACOG; **CON:** Priscilla Martens, Washington Evangelicals for Responsible Government; Jeff Kemp, Washington Family Council; Robin Bernhoft, National Parent's Council; Jim Halstrom, Health Care Purchasers Association, Association of Washington Business; **CONCERNS:** Eric Paige, Washington State Catholic Conference.

HOME | SEARCH

STATE OF CONNECTICUT

AMENDMENT

LCO No. 4250

General Assembly

February Session, A.D., 1998

offered by SEN. JEPSEN, 27th DIST.

SEN. DELUCA, 32nd DIST.

SEN. BOZEK, 6th DIST.

To Senate Bill No. 400

File No. 545

Cal No. 148

Entitled: "AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR
PRESCRIPTION BIRTH CONTROL."

In line 1, after "(NEW)" insert "(a)"

After line 12 insert the following:

"(b) Notwithstanding any other provision of this section, any insurance company, hospital or medical service corporation, or health care center may issue to a religious employer an individual health insurance policy that excludes coverage for prescription contraceptive methods which are contrary to the religious employer's bona fide religious tenets.

(c) Any health insurance policy issued pursuant to subsection (b) of this section shall provide written notice to each insured or prospective insured that prescription contraceptive methods are excluded from coverage pursuant to said subsection. Such notice shall appear, in not less than ten point type, in the policy, application and sales brochure for such policy.

(d) Nothing in this section shall be construed as authorizing an individual health insurance policy to exclude coverage for prescription drugs ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes.

(e) Notwithstanding any other provision of this section, any insurance company, hospital or medical service corporation, or health care center which is owned, operated or substantially controlled by a religious organization which has religious or moral tenets which conflict with the requirements of this act may provide for the coverage of prescription contraceptive methods as required under this section through another such entity offering a limited benefit plan. The cost, terms and availability of such coverage shall not differ from the cost, terms and availability of other prescription coverage offered to the insured.

(f) As used in this section, "religious employer" means an employer that is a "qualified church-controlled organization" as defined in 26 USC 3121."

In line 13, after "(NEW)" insert "(a)"

After line 23 add the following:

"(b) Notwithstanding any other provision of this section, any insurance company, hospital or medical service corporation, or health care center may issue to a religious employer a group health insurance policy that excludes coverage for prescription contraceptive methods which are contrary to the religious employer's bona fide religious tenets.

(c) Any health insurance policy issued pursuant to subsection (b) of this section shall provide written notice to each insured or prospective insured that prescription contraceptive methods are excluded from coverage pursuant to said subsection. Such notice shall appear, in not less than ten point type, in the policy, application and sales brochure for such policy.

(d) Nothing in this section shall be construed as authorizing

a group health insurance policy to exclude coverage for prescription drugs ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes.

(e) Notwithstanding any other provision of this section, any insurance company, hospital or medical service corporation, or health care center which is owned, operated or substantially controlled by a religious organization which has religious or moral tenets which conflict with the requirements of this act may provide for the coverage of prescription contraceptive methods as required under this section through another such entity offering a limited benefit plan. The cost, terms and availability of such coverage shall not differ from the cost, terms and availability of other prescription coverage offered to the insured.

(f) As used in this section, "religious employer" means an employer that is a "qualified church-controlled organization" as defined in 26 USC 3121."

TOP

FAX TRANSMITTAL SHEET

U. S. OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
1900 E STREET, N.W., ROOM 4A10
WASHINGTON, D.C. 20415

Telephone (202) 606-0600

Number of Pages 3
(Including Cover Sheet)

TO: Chris Jennings

DATE: _____

Telephone Number _____

Fax Number _____

FROM: Ed J Lynn

DATE: 4/22/99

Telephone Number _____

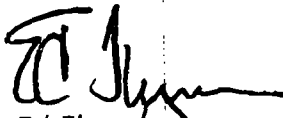
Fax Number _____

COMMENTS: _____

Note for Chris Jennings:

Chris, here is the paper on contraceptive coverage that we discussed. The FEHB Buy-In (a la Medicare) is about ready, but needs a little more work. Will get that to you quickly.

On the topic we talked about the other day (Medicare and Blue Cross and Blue Shield looking similar in 1965), we are probably not going to be of much help. When the FEHB was established in 1960, the law setting it up required coverage for prescription drugs - fully 5 years before the establishment of Medicare. We are nonetheless, going through a history of the Blue Cross and Blue Shield benefits since 1965 in order to identify the major shifts in the evolution of their benefit design (preventative benefits and others), and should have that done by early next week.


Ed Flynn
April 22, 1999

Attachment

CONTRACEPTIVE COVERAGE IN THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

U.S. OFFICE OF PERSONNEL MANAGEMENT

April 22, 1999

- In 1998, 350 plans participated in the FEHB Program. All plans except 33 covered at least some contraceptive drugs or devices. Five of the 33 objected to coverage on religious grounds.
- In 1999, as the result of Public Law 105-277, all FEHB plans now cover the full range of FDA-approved prescriptions and devices for birth control, except for the five plans that previously objected on religious grounds and that are specifically exempted by the law.
- Implementation of the law occurred smoothly, without incident. Because 1999 premiums had already been set when contraceptive coverage was mandated, the increased coverage had no effect on 1999 premiums. We told carriers we would adjust 1999 premiums during the annual premium reconciliation process, but we expect premium increases due to contraceptives, if any, to be insignificant.
- We have no information at this point – not even anecdotal information – about utilization of these benefits.
- In addition to the plans specifically exempted from providing coverage of contraceptives, the law provides that other plans may decline to provide coverage on religious grounds. No plans have asked to be exempted.
- The law also provides that plans may not discriminate against plan providers whose individual religious beliefs or moral convictions prevent them from prescribing contraceptives. In such a case, the plan is required to arrange for the enrollee to see a provider who will prescribe contraceptives. We have no information to show that this has actually occurred. Certainly, we have not received any complaints about it. [This has applicability only to HMO plans, since enrollees in fee-for-service plans are always free to select their own providers.]
- Our guidance to carriers instructed them to cover contraceptives within their existing benefit structures. Related services such as office visits for fittings and/or counseling would also be covered in accordance with the health plan's benefit design. We are not aware of any plan in the Federal Employees Health Benefits Program that excludes such coverage from its benefit design.