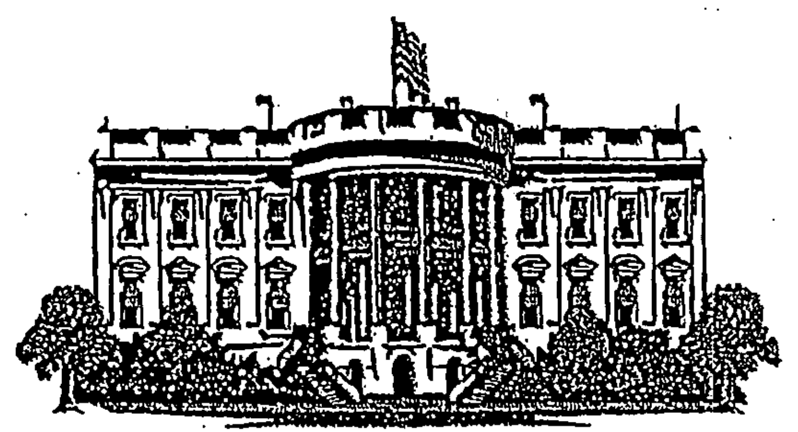
NLWJC - Kagan

DPC - Box 028 - Folder 015

Health - EPICC Bill

THE WHITE HOUSE

Health - EPIC legislation



Christopher C. Jennings
Deputy Assistant to the President for Health Policy
216 Old Executive Office Building
Washington, DC 20502
phone: (202) 456-5560
fax: (202) 456-5557

Facsimile Transmission Cover Sheet

To: Elena

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Comments: Jenny wants to discuss the best way to include conscience clause language in the statement. Pls call when you can.

6-9-99

THE WHITE HOUSE

WASHINGTON

June 9, 1999

copied
Jennings
Cahill
Luray
Podesta

MR. PRESIDENT:

The attached Jennings/Cahill/Luray memo seeks a decision on endorsing the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC), which will be introduced tomorrow.

Like the FEHBP mandate you signed into law last year, this bi-partisan bill would require health plans to cover prescription contraceptives, if they cover other prescription drugs. Women's and pro-choice groups have made EPICC a top legislative priority.

Issues. There are two primary issues: First, the bill lacks a "conscience clause" allowing plans with religious objections to opt out; women's/choice groups oppose such a clause on tactical and substantive grounds. The Administration believes their approach is misguided – that it's important to acknowledge religious objections. Second, like other coverage proposals (*e.g.*, mental health, substance abuse treatment), EPICC could increase premiums (about 1%).

Option 1. Endorse EPICC, while signaling your willingness to work on conscience clause language, thereby implying support for the clause without offending women's groups. *DPC, OMB, and OPL/Women's Office* support this option. They think the bill's conscience clause omission is a mistake, but that you should support women's groups on this issue.

Option 2. Do not endorse, but work behind the scenes to pass legislation with a conscience clause, thereby avoiding criticism for imposing insurance mandates while developing a workable conscience-clause compromise. *HHS would prefer no endorsement if you are likely to endorse other premium-increasing coverage mandates because the cumulative impact would undermine our credibility on the cost/coverage issue.*

✓ Option 1 _____Option 2 _____Discuss

But I would make clear that I favor a conscience clause

Sean Maloney
David Goodfriend

THE WHITE HOUSE
WASHINGTON

June 8, 1999

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings
Mary Beth Cahill
Jenny Luray

SUBJECT: Impending Introduction of Contraceptive Coverage Legislation

We expect a bipartisan group of Congressional members to introduce the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC) this Thursday. The legislation would require health plans to cover prescription contraceptive coverage if they cover other prescription drugs; it is generally consistent with the measure you signed into law last year mandating such coverage in all plans participating in the Federal Employees Health Benefits Plan (FEHBP). This memorandum provides background information on this issue and seeks guidance as to whether you want to endorse the bill when it is introduced.

BACKGROUND

Current Coverage Status. While well over 80 percent of private insurance plans cover prescription drugs in general, only about one-third cover the costs of oral contraceptives (the most commonly used birth control method). HMOs provide slightly better oral contraceptive coverage but only 39 percent cover all five leading methods. According to the Kaiser Family Foundation, three out of every four women say that cost is an important factor when choosing between a birth control method that is covered and one that is not. Moreover, women of childbearing age spend 68 percent more in out-of-pocket health care costs than men do, although there is no specific breakout as to what percentage is for contraception.

EPICC Legislation. EPICC was first introduced in the last Congress by Senators Reid and Snowe and Representatives Lowey and Greenwood. This legislation would require insurance plans to cover all FDA approved forms of contraception if and to the extent that they cover other prescription drugs. The bill also would require plans to provide outpatient contraceptive services (such as exams and fittings) in the same manner as they cover other outpatient medical services. Similar legislation has been introduced in 19 states in the last two years, and Maryland and Georgia recently became the first states to enact such laws.

When it became clear that this legislation could not be passed last year, EPICC's sponsors focused their attention on working on encouraging the Congress to extend these protections to FEHBP plans. After a lengthy fight over "conscience clause" language, Congresswoman Lowey -- with the

help of the Administration -- secured passage of the FEHBP provision in the Omnibus Appropriations measure you signed last fall. Leading women's groups and the pro-choice community hailed this as a major victory. The same group of supportive Members, along with supportive women's and pro-choice groups are now turning their attention to winning contraceptive coverage for those in all private plans.

Policy Arguments for EPICC. The women's and pro-choice communities believes that EPICC provides an all-too-rare opportunity to promote a positive agenda. Better contraceptive coverage means fewer unintended pregnancies, which means fewer abortions. For this reason, EPICC is now a top legislative priority for many of the leading women's and pro-choice organizations.

Endorsing this legislation would be consistent with your past position on FEHBP and would once again position us on a women's health issue that has strong policy rationale. It strengthens our hand on the pro-choice agenda and would be extremely well received by the women's advocacy community. Just as important, your endorsement would make a substantive contribution towards increasing the likelihood that this legislation would pass the Congress this year.

Mandates and Potential Impact on Cost/Coverage. We generally have avoided endorsing bills that impose insurance coverage requirements -- particularly when they are initially introduced. We have taken this position for two reasons: (1) to avoid the criticism that such "rifle shot" requirements increase premiums and thereby increase the number of uninsured and (2) to avoid starting down the slippery slope of supporting a slew of other insurance requirements.

As you know, you already support the Patients' Bill of Rights legislation, which although mostly requiring procedural rather than coverage requirements, is projected by CBO to increase premiums by about 4 percent). In addition, you have been asked to support legislation to impose further coverage requirements for mental health and substance abuse treatment and to assess a 1 percent premium fee on private plans to help finance the cost of training physicians in teaching hospitals and academic health centers. Although EPICC is projected to add only 1 percent to average private sector premiums, the accumulation of these policy initiatives could make us vulnerable the criticism that we are decreasing the affordability of insurance.

Conscience Clause Issue. One notable shortcoming of the current EPICC bill is that it does not include a "conscience clause" for plans that have religious objections to providing contraceptive coverage. Although the bill's sponsors and the pro-choice community recognize that this issue will have to be addressed before any bill reaches your desk, they oppose including any "conscience clause" language at the time of introduction. They are taking this position for two main reasons. First, they believe that the "conscience" problem is not as great in the context of contraception as in the context of abortion. Second, they believe that adding such language could leave too many women without access to contraceptives in light of Catholic-affiliated providers participating in the managed care market. The sponsoring members and groups would rather deal with this issue as and when it arises than introduce a bill that they believe already represents a significant compromise.

We believe that the advocates' position on this matter is mistaken, and that it is important to signal up-front an explicit commitment to accommodate plans with religious scruples. To omit it makes advocates vulnerable with respect to an issue that they will lose in the end. In addition, omitting conscience language makes the bill supporters vulnerable to a "double-standard" charge; they are willing to support such language when it applies to the Congress and federal health plans, but not when it applies to health plans in the private sector. The sponsoring members and groups, however, have rejected our advice on this issue.

OPTIONS

The following are the most viable options for your consideration:

(1) **Issue a statement of support for the new legislation, but do so in a manner that subtly signals your willingness to work on conscience clause language.** Under this scenario, you would release a statement at the time of introduction that notes your support for similar legislation last year and calls on the Congress to take further action, applying to private health plans, on this high priority issue. Such a statement would imply support for a conscience clause (since last year's bill had one), but would not offend the pro-choice community at the time of introduction.

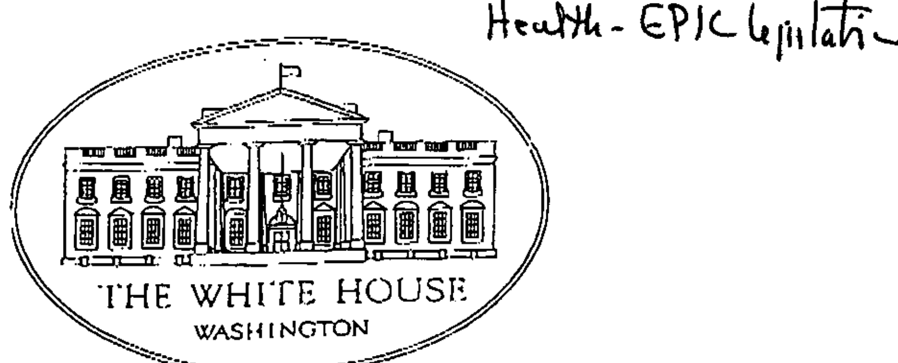
(2) **Not endorse this legislation, but work behind the scenes to get legislation passed with an appropriate conscience clause.** Under this approach, you would take no formal position at the time of introduction, but advise the pro-choice community that we will provide technical and strategic support to pass this bill on Capitol Hill. Such an approach would allow you to avoid criticism relating to the cost of imposing insurance mandates and also would allow us to develop a workable conscience-clause compromise.

White House and Agency Positions on These Options. DPC, the Women's Office, the Office of Public Liaison, and OMB support option one. Although believing that the pro-choice community is making a significant error by not including a conscience clause provision in the bill at the time of introduction, these offices believe we should respond positively to the women's community on this key legislative priority and provide momentum to a bill guaranteeing equity for women at a low cost. In addition, these offices believe that the Administration should provide early support for this positive, proactive message on choice. HHS believes that this decision depends on whether you are likely to endorse other coverage mandates (like mental health parity) in the near future (like mental health parity); if you are, they would support option 2 because the cumulative impact of these endorsements will undermine our credibility on the cost/coverage issue.

Office of the Vice President. The Vice President's Office is now determining whether it might be advisable for the Vice President to be the lead advocate for this legislation out of the White House. If so, they will report back tomorrow and will make a request to you through DPC.

Option 1: __________ Option 2: __________ Let's Discuss: __________

Health - EPIC legislation



OFFICE FOR WOMEN'S INITIATIVES AND OUTREACH

TO: Elena

FAX: 62878

DATE:

NUMBER OF PAGES (INCLUDING COVER SHEET): 20 (1-10)

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

NOTES:

Let's talk on Wednesday.

The bill may be dropped next week.

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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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 contraceptive 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 covering 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)

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 contraceptive 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."

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.

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.

December 1998

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CA

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

OFFICE FOR WOMEN'S INITIATIVES AND OUTREACH

TO: Elena

FAX: 62878

DATE:

NUMBER OF PAGES (INCLUDING COVER SHEET): 2~~0~~ ~~(1-10)~~ (11-21)

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

NOTES:

Let's talk on wednesday.

The bill may be dropped next week.

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
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(19-21)

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

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.

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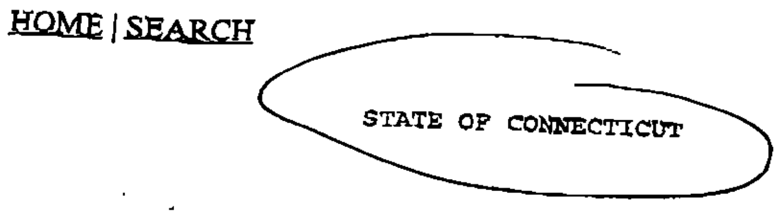

AMENDMENT

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

Health-EPIC legislation

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 contact 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.

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 contraceptive 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 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 covering 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.

Models in both public policy and private-sector action 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)

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 contraceptive 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."

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.

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. ⊕

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.

APR-23-99 FRI 02:03-PM FAX NO. 2235756 P.04

(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:

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"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

(19-21)

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

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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

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

APR-23-99 FRI 02:05 PM FAX NO. 2235756 P.11

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.

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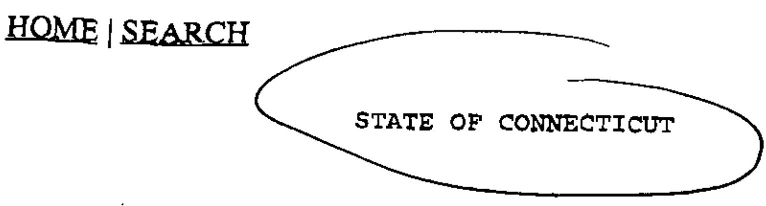

AMENDMENT

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

Health - EPIC bill

THE WHITE HOUSE

WASHINGTON

May 18, 1999

MEMORANDUM TO THE PRESIDENT

FROM: Bruce Reed
Chris Jennings
Mary Beth Cahill
Jennie Luray

SUBJECT: Impending Introduction of Contraceptive Coverage Legislation

We expect a bipartisan group of Congressional members to introduce the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC) this week. The legislation would require health plans to cover prescription contraceptive coverage if they cover other prescription drugs; it is generally consistent with the measure you signed into law last year mandating such coverage in all plans participating in the Federal Employees Health Benefits Plan (FEHBP). This memorandum provides background information on this issue and seeks guidance as to whether you want to endorse the bill when it is introduced.

BACKGROUND

Current Coverage Status. While well over 80 percent of private insurance plans cover prescription drugs in general, only about one-third cover the costs of oral contraceptives (the most commonly used birth control method). HMOs provide slightly better oral contraceptive coverage but only 39 percent cover all five leading methods. According to the Kaiser Family Foundation, three out of every four women say that cost is an important factor when choosing between a birth control method that is covered and one that is not. Moreover, women of childbearing age spend 68 percent more in out-of-pocket health care costs than men do, although there is no specific breakout as to what percentage is for contraception.

EPICC Legislation. EPICC was first introduced in the last Congress by Senators Reid and Snowe and Representatives Lowey and Greenwood. This legislation would require insurance plans to cover all FDA approved forms of contraception if and to the extent that they cover other prescription drugs. The bill also would require plans to provide outpatient contraceptive services (such as exams and fittings) in the same manner as they cover other outpatient medical services. Similar legislation has been introduced in 19 states in the last two years, and Maryland and Georgia recently became the first states to enact such laws.

When it became clear that this legislation could not be passed last year, EPICC's sponsors focused their attention on working on encouraging the Congress to extend these protections to FEHBP

plans. After a lengthy fight over "conscience clause" language, Congresswoman Lowey -- with the help of the Administration -- secured passage of the FEHBP provision in the Omnibus Appropriations measure you signed last fall. Leading women's groups and the pro-choice community hailed this as a major victory. The same group of supportive Members, along with supportive women's and pro-choice groups are now turning their attention to winning contraceptive coverage for those in all private plans.

Policy Arguments for EPICC. The women's and pro-choice communities believes that EPICC provides an all-too-rare opportunity to promote a positive agenda. Better contraceptive coverage means fewer unintended pregnancies, which means fewer abortions. For this reason, EPICC is now a top legislative priority for many of the leading women's and pro-choice organizations.

Endorsing this legislation would be consistent with your past position on FEHBP and would once again position us on a women's health issue that has strong policy rationale. It strengthens our hand on the pro-choice agenda and would be extremely well received by the women's advocacy community. Just as important, your endorsement would make a substantive contribution towards increasing the likelihood that this legislation would pass the Congress this year.

Mandates and Potential Impact on Cost/Coverage. We generally have avoided endorsing bills that impose insurance coverage requirements -- particularly when they are initially introduced. We have taken this position for two reasons: (1) to avoid the criticism that such "rifle shot" requirements increase premiums and thereby increase the number of uninsured and (2) to avoid starting down the slippery slope of supporting a slew of other insurance requirements.

As you know, you already support the Patients' Bill of Rights legislation, which although mostly requiring procedural rather than coverage requirements, is projected by CBO to increase premiums by about 4 percent). In addition, you have been asked to support legislation to impose further coverage requirements for mental health and substance abuse treatment and to assess a 1 percent premium fee on private plans to help finance the cost of training physicians in teaching hospitals and academic health centers. Although EPICC is projected to add only 1 percent to average private sector premiums, the accumulation of these policy initiatives could make us vulnerable the criticism that we are decreasing the affordability of insurance.

Conscience Clause Issue. One notable shortcoming of the current EPICC bill is that it does not include a "conscience clause" for plans that have religious objections to providing contraceptive coverage. Although the bill's sponsors and the pro-choice community recognize that this issue will have to be addressed before any bill reaches your desk, they oppose including any "conscience clause" language at the time of introduction. They are taking this position for two main reasons. First, they believe that the "conscience" problem is not as great in the context of contraception as in the context of abortion. Second, they believe that adding such language could leave too many women without access to contraceptives in light of Catholic-affiliated providers participating in the managed care market. The sponsoring members and groups would rather deal with this issue as and when it arises than introduce a bill that they believe already represents a significant compromise.

We believe that the advocates' position on this matter is mistaken, and that it is important to signal up-front an explicit commitment to accommodate plans with religious scruples. To omit it makes advocates vulnerable with respect to an issue that they will lose in the end. In addition, omitting conscience language makes the bill supporters vulnerable to a "double-standard" charge; they are willing to support such language when it applies to the Congress and federal health plans, but not when it applies to health plans in the private sector. The sponsoring members and groups, however, have rejected our advice on this issue.

OPTIONS

The following are the most viable options for your consideration:

(1) **Issue a statement of support for the new legislation, but do so in a manner that subtly signals your willingness to work on conscience clause language.** Under this scenario, you would release a statement at the time of introduction that notes your support for similar legislation last year and calls on the Congress to take further action, applying to private health plans, on this high priority issue. Such a statement would imply support for a conscience clause (since last year's bill had one), but would not offend the pro-choice community at the time of introduction.

(2) **Not endorse this legislation, but work behind the scenes to get legislation passed with an appropriate conscience clause.** Under this approach, you would take no formal position at the time of introduction, but advise the pro-choice community that we will provide technical and strategic support to pass this bill on Capitol Hill. Such an approach would allow you to avoid criticism relating to the cost of imposing insurance mandates and also would allow us to develop a workable conscience-clause compromise.

White House and Agency Positions on These Options. DPC, the Women's Office, the Office of Public Liaison, and OMB support option one. Although believing that the pro-choice community is making a significant error by not including a conscience clause provision in the bill at the time of introduction, these offices believe we should respond positively to the women's community on this key legislative priority and provide momentum to a bill guaranteeing equity for women at a low cost. In addition, these offices believe that the Administration should provide early support for this positive, proactive message on choice. HHS believes that this decision depends on whether you are likely to endorse other coverage mandates (like mental health parity) in the near future (like mental health parity); if you are, they would support option 2 because the cumulative impact of these endorsements will undermine our credibility on the cost/coverage issue.

Option 1: _________ Option 2: __________ Let's Discuss: ___________