

Contraceptive Coverage: Toward Ensuring Access While Respecting Conscience

By Rachel Benson Gold

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

Government as Employer

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

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

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

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

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

Private Sector Challenges

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

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

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

When Providers Opt Out

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

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

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

When Employers Opt Out

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

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

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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-

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

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

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

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

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

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

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