

State Legislators in 1998: On Two Roads to Goal of ‘Prevention’

In the midst of the ongoing abortion controversy, state legislators on both sides of the divide also advanced policies under the rubric of “prevention.” Reproductive rights advocates did so by promoting easier access to women’s health services in managed care plans as well as insurance coverage of contraceptives; antiabortion, “pro-family” legislators—seeking to deter sexual activity among teenagers and outside of marriage—focused their efforts on statutory rape law enforcement and school-based abstinence education.

By Patricia Donovan, Emily Figdor and Adam Sonfield

In 1998, reproductive health-related issues continued to garner the attention of state policymakers nationwide. As has been the case for many years, controversies over abortion—especially efforts to criminalize what antiabortion organizations have dubbed “partial-birth” abortion—dominated the debate (*TGR*, Vol. 1, No. 6, December 1998). However, partisans on each side, concerned that the public may be frustrated with this ongoing wrangling over abortion, also focused their efforts on issues of “prevention.” The manner in which they did so, however—either by seeking to increase access to preventive reproductive health care or by seeking to discourage nonmarital sexual activity entirely—demonstrates the starkly different values at the core of their respective agendas.

Reproductive rights and women’s health proponents in the states, as in Congress, made significant headway last year toward forging two industrywide insurance standards intended to increase access to reproductive health care: allowing women in managed care plans to have “direct access” to women’s health services and mandating private-sector insurance coverage of contraceptive services and supplies.

Antiabortion, “profamily” legislators, meanwhile, continued to press themes raised during the recent national welfare reform debate around curtailing sexual activity—

and, thereby, pregnancy and childbearing—among adolescents and outside of marriage. Toward that end, they advocated for vigorous enforcement of statutory rape laws as well as promotion in public school classrooms of abstinence from sexual activity outside of marriage.

Direct Access

To control service utilization, many managed care plans require prior authorization for services obtained from a clinician other than a primary care provider. For women seeking reproductive health care, such requirements frequently create obstacles that hinder timely and confidential access to services. The President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry addressed this concern early in 1998, when it issued the Consumer Bill of Rights and Responsibilities, which, among other recommendations, called for managed care plans to provide “direct access” to women’s health care. The Commission’s recommendation ushered in direct access as one of the major principles of managed care reform (*TGR*, Vol. 1, No. 3, June 1998).

Soon after the release of the report, at the direction of President Clinton, the Office of Personnel Management ordered plans participating in the Federal Employees Health Benefits Program to provide direct access to women’s health care. During 11th-hour negotiations over an omnibus FY 1999 spending bill, however, Congress failed to approve an initiative that would have required direct access in all private-sector insurance plans.

The states, meanwhile, have long been at the forefront of the movement to secure direct access to women’s health care. In 1994, Maryland became the first state to mandate that managed care plans provide women

DIRECT ACCESS TO WOMEN’S HEALTH SERVICES: LAWS ENACTED IN 1998

STATE	EXPANDED EXISTING LAW	ENACTED NEW LAW
CALIFORNIA	X	
COLORADO	X	
ILLINOIS	X	
KENTUCKY		X
MICHIGAN		X
NEW HAMPSHIRE		X
PENNSYLVANIA		X
SOUTH CAROLINA		X
TENNESSEE		X
UTAH	X	
WEST VIRGINIA		X

**CONTRACEPTIVE COVERAGE:
MAJOR DEVELOPMENTS IN 1998**

STATE	1998 ACTION	INCLUDED CONSCIENCE CLAUSE
ALASKA	•	3
CALIFORNIA	6	3
CONNECTICUT	•	3
FLORIDA	•	3
GEORGIA	•	
INDIANA	•	
MARYLAND	H	3
MASSACHUSETTS	•	
MISSOURI	•	
NEW YORK	•	
OKLAHOMA	•	
UTAH	•	

•=Seriously considered 6=Vetoed H=Enacted

access to reproductive health services without requiring them to gain prior approval from either a network provider or the plan. Maryland did this by allowing women to designate an obstetrician-gynecologist as their primary care provider. Subsequently, other states have taken a different approach, requiring plans to permit women to choose a separate provider of women's health care in addition to their primary care provider. Some states have afforded women both options.

In 1998, 11 states passed laws intended to facilitate access to women's health services, bringing to 38 the number of states that require at least some form of direct access. In four states, the new laws expand existing direct access requirements; in the remaining seven states, the measures mark a first attempt to guarantee women the right to direct access (see table, page 8).

The states with laws already on the books amended their policies to make direct access services more obtainable for women. Colorado, for example, added the option of obtaining services directly from certified nurse-midwives (in addition to obstetrician-gynecologists), while Illinois established a series of procedures to ensure that women are informed of the direct access policy.

Similarly, many of the states that passed direct access requirements for the first time last year enacted measures that give women an increasing number of options for accessing services and include some basic consumer protections. The new law enacted in West Virginia, for instance, requires plans to allow women to receive direct access services from a range of women's health care providers—including obstetrician-gynecologists, advanced

nurse practitioners, certified nurse-midwives and physician assistants—and to inform women, in clear and accurate language, about their right to direct access services.

These developments notwithstanding, many of the state laws enacted in 1998, in the interest of “continuity of care,” require that primary care providers be informed of services obtained from women's health care providers. This, in turn, raises confidentiality issues that, some argue, could undermine the utility of direct access policies.

Contraceptive Coverage

Initiatives to require health insurance to include coverage of contraceptive services and supplies as a standard benefit received substantial attention in 1998. By year's end, the issue had advanced considerably at the federal level, and measures to require contraceptive coverage had been introduced in 20 states and seriously considered in 12 (see table).

As part of its final budget negotiations, Congress approved a landmark measure to require contraceptive coverage in federal employees' health plans. Within weeks, the Office of Personnel and Management sent letters to the 285 plans participating in the federal health insurance program advising them of the new requirement, and to all federal agencies directing them to inform their employees of this new benefit (*TGR*, Vol. 1, No. 6, December 1998).

Earlier in the year, in another major victory for proponents of contraceptive coverage, Maryland became the first state to require private-sector insurance coverage of contraceptive services and supplies. Maryland law now guarantees coverage of all contraceptive methods approved by the Food and Drug Administration as well as associated medical examinations and procedures.

Meanwhile, in California, where proponents struggled for three years to craft a measure to satisfy then-governor Pete Wilson (R), state lawmakers passed contraceptive coverage legislation twice during the year, in February and again in September. Each time, however, the effort was thwarted by Wilson's veto. Despite these setbacks, proponents expect to pass contraceptive coverage early in 1999 and to gain approval from California's new governor, Gray Davis (D).

Contraceptive coverage measures received serious consideration in a number of other states as well. In Connecticut, a bill overwhelmingly passed the Senate, but was held up by the threat of “partial-birth” abortion amendments in the House. Similar measures in Alaska and New York also passed one house, but both states' legislatures adjourned for the year without taking further action on them.

STATUTORY RAPE: ONE STATE'S LAW (Mississippi, Enacted 1998)			
AGE OF PERPETRATOR	AGE OF VICTIM	REQUIRED AGE DIFFERENCE	PUNISHMENT
≥18	<14	NA	20 YEARS TO LIFE
≥21	14–15	NA	UP TO 30 YEARS/ \$10,000*
18–20	14	36 MONTHS	UP TO 5 YEARS/ \$5,000
17	14–15	36 MONTHS	COURT DISCRETION
13–17	<14	24 MONTHS	COURT DISCRETION
<i>NA = Not applicable * Up to 40 years for subsequent offenses</i>			

In California, the so-called conscience issue played a role in both of Wilson's vetoes. In his first veto statement last year, Wilson said that, since the legislation required all plans that cover prescription drugs to cover contraceptives, he feared that employers "that object to providing coverage for contraceptives could simply drop all coverage for prescription drug benefits." In September, however, Wilson rejected a contraceptive coverage bill that explicitly exempted religious employers from its requirements. This time, he objected to a provision that would have enabled employees who could not obtain contraceptive benefits as a result of their employer's exemption to obtain state-subsidized services.

The conscience issue also arose in other state debates, as policymakers found a number of ways to strike a balance between the ability of employers and insurers to claim a conscientious objection to covering contraceptive services and the right of individual employees to obtain care or coverage to which they are entitled. Maryland's new law, for instance, exempts religious employers from providing coverage of contraceptives if it conflicts with their "bona fide religious beliefs and practices," provided they give "reasonable and timely notice" of the exemption to their employees. Policymakers in Connecticut took a different approach by allowing religious health plans to provide contraceptive coverage through a separate, limited benefit plan, thereby providing the coverage at an arm's length.

Contraceptive coverage is expected to be a hot issue for state legislators again this year. In a recent survey by the National Conference of State Legislatures, contraceptive coverage was identified as a top health care priority for 1999 in exactly half of the states. The issue is also likely to be revisited in Congress, as proponents seek to extend to private-sector employees the coverage guarantee they secured for federal employees.

Statutory Rape

Until recently, most states' statutory rape laws—which define situations in which minors are deemed too young to consent to intercourse—largely have been ignored, at least in part because statutory rape is difficult to prosecute successfully and because the public has shown little interest in widespread prosecution. That dynamic began to change with the debate over welfare reform in the mid-1990s.

Fueled by studies indicating that at least half of all babies born to minors are fathered by adult men, many conservative state and federal policymakers embraced the notion that vigorous prosecution of older men who "prey" on young girls would be an effective strategy for preventing teenage pregnancy. With prevention of pregnancy and childbearing among adolescents and unmarried women one of the principal goals of the welfare reform effort, reinvigorating the enforcement of statutory rape laws became a focus of the federal welfare reform law enacted in 1996—as well as a central item on the ongoing conservative political agenda.

Indeed, welfare reform has triggered considerable legislative activity in the states designed to overcome some of the historic barriers to successful statutory rape prosecution. Since the beginning of 1996, at least 12 state legislatures, including four in 1998, have enacted measures aimed at achieving this goal—despite a dearth of evidence that locking up older men who have sex with minor girls will have a significant impact on pregnancy rates among unmarried teens and despite concerns about selective enforcement and the impact that enforcement could have on discouraging teens from seeking critical health care and support services (*TGR*, Vol. 1, No. 3, June 1998).

One approach, pioneered by California in 1995, has been to fund prosecutors and investigators assigned specifically to target statutory rape; such programs are designed to improve coordination of enforcement and to foster cooperation from victims and witnesses. Wisconsin enacted a similar pilot program last year, with the intention of "developing new methods for investigating, prosecuting and increasing the number of [statutory rape] convictions...."

However, a 1997 study by the American Bar Association's Center on Children and the Law indicates that even prosecutors who support rigorous enforcement of statutory rape laws do not believe that they have the support of other key groups or the general public. To rectify this problem, several states, including Mississippi in 1998, have followed a directive in the federal welfare reform law to establish statutory rape education and training

programs for law enforcement officials, counselors and educators. Other states over the past three years have initiated media campaigns to educate the public directly.

More commonly, legislators have addressed the lack of public support by taking a closer look at how the laws interpret statutory rape. Typically, newer statutes include multiple categories of illegal sexual activity, basing the severity of the crime upon the age of the “victim” and/or the age difference between the victim and the “perpetrator” (see box). Many states, however, still have laws with only a few such categories, and legislators in some of these states have taken steps to rewrite the statutes to encompass a wider range of circumstances—from older adult men involved with very young girls to consensual sex between teens.

Conservative lawmakers have taken the lead where they believe their existing state laws do not adequately punish and deter “predatory” relationships. These policymakers have promoted bills to add new categories of illegal activity that focus on great disparities in age. For example, a law passed in Delaware last year makes it a felony for a person 30 years or older to have sexual intercourse with a minor younger than 18; prior to this legislation, it was not a crime for adults to have sex with minors aged 16–17. Mississippi and Utah enacted similar provisions.

In other states, lawmakers have retained tough penalties for the most egregious cases while adding new legal categories to eliminate or reduce punishment for less disparate relationships, such as those between two minors. This tactic has met the approval of a wider coalition of lawmakers, some seeking to head off prosecutorial abuse and others wishing to provide tools for prosecutors who may be reluctant to try for conviction when the only available punishments seem overly harsh. In Wisconsin, for example, where a statutory rape conviction in a case involving two teens generated national attention, a measure to carve out a misdemeanor crime for teenage sex passed one chamber by a bipartisan vote before the legislature adjourned for the year. Moreover, the legislature enacted as part of its new pilot program a provision prohibiting perpetrators younger than 18 from being targeted for prosecution unless they were more than four years older than the victim.

Abstinence Education in Schools

A second progeny of the welfare reform movement—also under the rubric of reducing rates of teen and out-of-wedlock pregnancy—has been the expanded promotion of abstinence from sexual activity, spurred by the five-year, \$250 million “abstinence-only” education program included in the 1996 federal welfare reform act. Advocates of abstinence outside of marriage who had

worked hard for the new program complained throughout 1998 that many of the approved state plans under which the program’s first-year funding was allocated failed to adhere to the spirit and letter of the act, which characterizes nonmarital sexual activity as immoral and harmful to individuals and society. In particular, these conservative, “profamily” groups charged that the funds were being widely squandered on media campaigns and other indirect approaches, instead of being spent on direct educational programs, preferably in classroom settings.

Spurred on by these organizations, five state legislatures in 1998 enacted or seriously considered bills intended to require public school teachers to promote abstinence from sexual activity outside of marriage. Mississippi, for example, enacted a requirement that “[a]bstinence education shall be the state standard for any sex-related education taught in the public schools.” The law’s definition of abstinence education closely mirrors that of the federal law; the statute differs from the federal law, however, in allowing discussion of contraceptives, if it includes a “factual presentation” of risks associated with their use. It also allows individual school districts to opt out of the law’s standards. A measure enacted in December in Ohio establishes similar new abstinence promotion requirements within sexually transmitted disease education, but the measure specifically prohibits school districts from opting out of them. (Both new laws also require instruction on current statutory rape laws.)

Bills considered in Virginia and Washington also would have imposed curriculums emphasizing abstinence outside of marriage. The Virginia bill, vetoed because it attempted to restore a statewide family life education mandate, would have required such instruction to “present sexual abstinence before marriage and fidelity within monogamous marriage as moral obligations and not matters of personal opinion or personal choice” (*TGR*, Vol. 1, No. 3, June 1998). The Washington measure, which died after passing the state’s House of Representatives, would have amended AIDS education standards to require teaching the “dangers of sexual intercourse outside of a monogamous marriage.”

Finally, a new Utah law addresses both abstinence outside of marriage and pregnancy prevention, by requiring school districts that accept state funding for an adolescent pregnancy prevention program to base their activities on programs proven to modify student behavior in both of these areas. ☉

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