Future Uncertain for Catholic Plans' Creative Approaches To Providing Contraceptive Access

By Rachel Benson Gold

Whether health plans and employers should be allowed to claim a "corporate conscience" and refuse to provide or pay for reproductive health care services to which their beneficiaries are entitled is a hotly debated question in health care policymaking. Just this year, for example, legislation mandating insurance coverage of contraceptive services that had been passed by the Council of the District of Columbia, over whose laws Congress has final say, effectively was killed when the House formally objected to the fact that it did not include a "conscience clause."

Most often, the debate focuses on Catholic institutions. Yet, a new report shows that whether to protect their interest in the private-sector marketplace or their continued participation in the Medicaid program, many Catholic health plans have quietly found ways to provide access to contraceptive services and supplies for their enrollees. At the same time, recently proposed revisions to the ethical guidelines that govern the provision of medical care by Catholic institutions in the United States raise serious questions about whether these creative solutions will continue to be possible.

The new report, from Catholics for a Free Choice (CFFC), identifies 48 Catholic managed care plans nationwide, which together cover 2.5 million enrollees. Over half are for-profit entities, most often the for-profit subsidiaries of nonprofit hospital systems. Whether for-profit or not-for-profit, most of the plans are owned by Catholic health systems—networks of providers that include at least two hospitals—and enrollees generally obtain their care from the system's facilities. According to CFFC, about half of Catholic managed care plans have found a way to provide some access to tubal ligation or reversible contraception for their enrollees, although some plans limit coverage to oral contraceptives; none of the plans covers abortion services (see chart).

The plans providing contraceptive access, according to CFFC, have found creative ways of distancing themselves from the actual provision of—and often payment for—the services, through one of three general approaches. Some contract with non-Catholic providers to provide the services they do not wish to provide themselves. Others separate out the amount of the premium that would be used to cover these services and contract with a third-party administrator to handle payment for that care. Still others actually contract with another insurer to handle coverage for these services, sometimes through an entirely separate rider or agreement with the employer.

The Medicaid Mandate

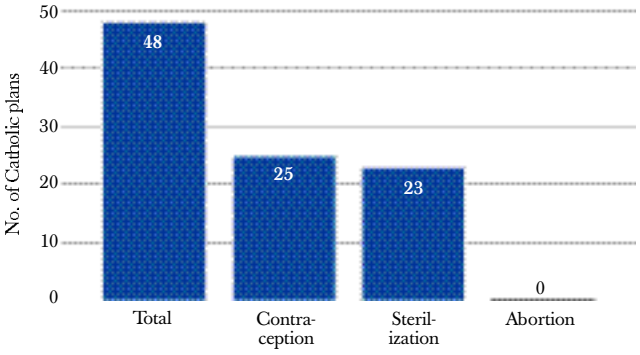
Medicaid, the joint federal-state program that insures the poorest of the poor, covers about 41 million individuals nationwide. Under federal law, family planning is one of the few services that is required to be included in all state programs, giving Medicaid recipients a legal entitlement to family planning services and supplies. This mandate has proven to be a crucial foundation upon which access to care can be built.

Only 15 of the 48 Catholic plans in the United States serve Medicaid recipients; together, these plans cover approximately 770,000 enrollees, or about 2% of all Medicaid enrollees nationwide. Perhaps not surprisingly, given the federal mandate, CFFC found that 13 of these 15 plans have found a way to provide access to some family planning services for enrollees. All 13 of these plans cover contraception, while most cover sterilization as well.

The linchpin of many of these agreements is a requirement by the state, resulting from the federal mandate, that managed care plans desiring to sign contracts commit themselves to providing access to the full range of Medicaid benefits, including family planning. This requirement effectively means that if a Catholic plan is to participate in Medicaid, it must provide some access to family planning, even if at arm's length from the plan itself. While some of these provisions are quite general, others, like the contract between the Texas Department of Health and the Seton Health Plan, are specific to family planning. That contract requires the

Catholic Plans and Reproductive Health Care

Half of Catholic managed care plans in the United States have found a way to provide access to contraception or sterilization; no plan provides abortion.



Source: Miller P and Chelala C, *Catholic HMOs and Reproductive Health Care*, Washington, DC: Catholics for a Free Choice, 2000.

plan to "provide, at a minimum, the full scope of services available under the Texas Medicaid program for family planning services."

Different administrative models result in different avenues through which enrollees can access the services to which they are entitled. For example, in Arizona, where the state requires all health plans with which it contracts to provide access to family planning services, the Catholic Mercy Care Plan subcontracted with an administrative agency, Kachina Administrative Services, to arrange and pay for family planning for Mercy Care members. According to Rochelle Tigner of the state's Medicaid program, the Arizona Health Care Cost Containment System, her office worked closely with Mercy and Kachina to meet the needs of both the enrollees and the religious plan.

The state separates out the funds to be used for family planning and sends those funds directly to Kachina; Mercy never "touches" the money. Kachina, for its part, contracts independently with most of Mercy's primary care and obstetric providers for family planning services; these providers then bill Kachina, rather than Mercy, for the family planning services they provide. From the enrollees' perspective, however, this bifurcated system is largely invisible. For the most part, they obtain family planning services from the same providers from which they obtain their other care.

While the Arizona system relies largely on Mercy's network of physicians, an arrangement in Pennsylvania takes a different approach, by using an existing network of family planning clinics to provide the services. This arrangement also grew out of a state requirement, in this case a statute mandating that plans "have arrangements with other providers for referring recipients for services for which they are eligible under the Medicaid Assistance Program but which are not provided" directly by the plan.

Two commercial plans in the Philadelphia area, the Catholic Mercy Health System and Keystone Health Plan East, a nonsectarian Blue Cross/Blue Shield plan, joined together to form Keystone/Mercy Health Plan to serve Medicaid recipients. The member handbook for the joint Medicaid plan explicitly states that a plan doctor cannot provide family planning and sterilization services. Instead, the services are available through Keystone, the nonsectarian component of the partnership. Keystone, in turn, contracts with the Family Planning Council of Philadelphia, which provides Keystone/Mercy's enrollees access to confidential care at 88 family planning clinic sites throughout the service area. Enrollees may either go to the clinics directly or call Keystone for help in locating a clinic.

An Uncertain Future

These creative arrangements are based on the Catholic doctrine of material cooperation, under which a Catholic institution may "cooperate" in an act that the Church considers immoral if doing so prevents an even greater harm, such as a hospital's closing or a reduced availability of care for the poor. "Our Catholic mission," according to Kathryn Aurelius of the Mercy Care Plan in Arizona, "is to do a good job taking care of our people. Our job is to figure out how best to do that."

Currently, the Church's Ethical and Religious Directives for Catholic Health Care Services permits material cooperation, with the notable exception of activities related to abortion, which is considered so "intrinsically evil" as to preclude cooperation in any form, no matter how indirect. Even so, several recent applications of this doctrine, usually involving the continuation of sterilization services following the merger of a Catholic institution with a secular institution, have drawn severe criticism from the Vatican ("Advocates Work to Preserve Reproductive Health Care Access When Hospitals Merge," *TGR*, April 2000, page 3).

This criticism has led to the undoing of some of these creative solutions over the past few years, and now, the National Conference of Catholic Bishops—at the urging of the Vatican—is moving to revise the ethical directives themselves. Revisions being circulated to the bishops for discussion would label sterilization, along with abortion, as "intrinsically evil." An appendix would go even further to state that material cooperation is permissible in rare cases, but only "for individuals, not for corporate entities." Together, these revisions could prohibit Catholic institutions—clearly Catholic hospitals, but potentially Catholic health plans as well—from making *any* arm's-length arrangements to provide access to either abortion or sterilization.

As currently drafted, the revisions would apply explicitly to sterilization, the most commonly used contraceptive method in the United States. Moreover, advocates such as Lois Uttley of MergerWatch worry that this language, if actually adopted, would affect the willingness of Catholic hospitals and plans to enter into or even continue arrangements to provide access to other reproductive health care services they cannot offer directly. This could throw into question many of the creative approaches that CFFC found plans to be taking to provide family planning services to either commercial or Medicaid enrollees.

The proposed revisions brought a swift protest from the Catholic Health Association, which represents 621 hospitals nationwide and is reportedly arguing that the revisions would jeopardize arrangements with

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secular facilities that Catholic hospitals need to survive. Apparently in response, the bishops struck the issue from the agenda of their November meeting, where it was slated to be discussed. A decision on the revisions is still expected by the bishops this spring.

Contraceptive Coverage Impact

Almost every debate over a contraceptive coverage mandate at the state or federal level has included a discussion of the "conscience" issue, and nine of the 13 state mandates now on the books include at least some exemption on the basis of religious beliefs. Most of these provisions allow "religious employers" to refuse to comply with the law because of their "bona fide religious tenets." (Interestingly, one of these states, Connecticut, specifically authorizes the arm's-length solutions that plans have developed.)

In one of the most recent examples of its political potency, the conscience issue is widely seen as having derailed enactment of the contraceptive coverage mandate for the District of Columbia this summer. When the Council of the District of Columbia passed a measure mandating contraceptive coverage without an exemption earlier this year, it quickly drew the attention of longtime family planning foe Rep. Ernest J. Istook (R-OK), chairman of the congressional subcommittee that oversees the District's federal funding. Istook threatened to enact language blocking enforcement of the mandate, and in fact, the House went on record with its intent to do so. In response, Mayor Anthony Williams (D) agreed to veto the measure, sending it back to the council for consideration at a later date.

Future debates over mandating contraceptive coverage, whether in the District or elsewhere, are likely to be shaped in no small measure by how the Catholic Church resolves the question of revising the ethical directives. If the bishops' conference takes a hard-line approach and prohibits plans and providers from making accommodations, it is likely to add to the pressure for conscience clauses, since the very ability of plans to fully participate in the health care marketplace—and particularly in Medicaid, which mandates access to family planning services for enrollees—will be at stake. On the other hand, if the bishops ultimately accede to these creative, arm's-length arrangements, legislators may be less inclined to enact exemptions that protect the "conscience" of corporate religious entities but vitiate the rights and may harm the health of individual beneficiaries. In that event, a considerable roadblock to health care marketplace reform may at last begin to give way.

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