States Key to Women's Family Planning Access Under New Medicaid Managed Care Rules

In June, the Bush administration issued final federal regulations implementing a set of provisions in the sweeping Balanced Budget Act of 1997 that constituted a virtual makeover of the joint federal-state Medicaid program for the managed care era. At the heart of the law's Medicaid provisions was a basic bargain between the federal government and the states: The states would have unfettered authority to require Medicaid recipients to enroll in managed care plans, in return for which they would abide by a series of federal requirements governing their Medicaid managed care efforts. Although regulations giving direction to the states as they moved to implement the measure were promulgated by the Clinton administration on its last full day in office, they were put on hold and subsequently revoked by the incoming Bush administration, which proposed new rules of its own. These rules, now finalized after public comment and set to take effect in August, have serious implications for the ability of Medicaid managed care enrollees to access "family planning services and supplies"—required services under the federal Medicaid statute to which all recipients are legally entitled.

The rules raise three key issues. The first involves the extent to which women in Medicaid managed care plans have direct access—that is, without having to seek permission from a primary care provider—to a separate provider for gynecologic care. Although the statute does not address this issue directly, the Clinton rules provided such access for "routine and preventive" women's health care. The Bush rules, as proposed, also included this policy. Advocates had urged that the final rules state specifically that family planning is included in a defined set of "routine and preventive" services for which direct access is to be permitted. But while the final rules do address the range of *providers* to whom women may have direct access (and specifically include nonphysicians such as nurse midwives and nurse practitioners), they do not contain any definition of the actual services for which direct access is to be permitted, leaving that decision to the individual states.

The second issue involves the information that the law requires be provided to managed care enrollees, either by the state or by the plans themselves, about both the services that are covered and how to access them. This is particularly important because, under the law, Medicaid enrollees may obtain family planning services from a provider of their choice inside or outside of their plan. The Clinton rules had required that enrollees be given information about their coverage at three key points: when they are choosing among plans, when they first enroll in a plan and annually thereafter. The Bush rules delete the last requirement, instead mandating that plans need annually inform enrollees only that they have a right to request information about their coverage.

The final issue arises from an ongoing problem with Medicaid managed care where family planning is concerned: the fact that Medicaid enrollees are legally entitled to obtain family planning services and supplies, but some managed care plans in which women are enrolled refuse to provide them. This problem was seriously exacerbated by a provision included in the Balanced Budget Act that now also allows managed care plans to refuse to cover a "counseling or referral service" to which they object on religious or moral grounds. While it remains the legal obligation of each state to ensure enrollees' access to covered services, the question is how to connect a woman in a managed care plan that refuses to provide family planning care, or even to refer for it, to the state that must ensure that she has access to it. While the Clinton rules would have narrowed the gap, advocates had urged the Bush administration to close it entirely. Their proposal was simple: Require states to establish a toll-free hot line through which enrollees could learn where to obtain counseling about a service or the service itself, and require plans refusing even to provide information about a service to which they object merely to give enrollees the state hot line number when they are asked about excluded care. But though the Bush administration acknowledged the request for a hot line, it declined to include the recommendation in the final rules, potentially leaving women without critical information about contraceptive care at the moment they need it the most.

In each of these instances, federal rule makers had the opportunity to include provisions that could have facilitated Medicaid managed care enrollees' access to family planning services. And in each of these instances, they declined. Accordingly, the focus now switches to the states. Advocates will have to work in 50 different arenas to ensure that the policies adopted for each individual state Medicaid program will provide enrollees the access to family planning services and supplies to which they are legally entitled.
—R. Gold

Twenty States Now Require Contraceptive Insurance Coverage

So far this year, lawmakers in New York, Arizona and Massachusetts have approved legislation requiring employer-sponsored health insurance plans that provide coverage for other prescription drugs also to cover prescription contraceptive drugs and devices approved by the Food and Drug Administration. Their actions bring to 20 the number of states with such mandates (see box). Each of the new laws takes effect in 2003, and in contrast to the opposition to such legislation among Republican leaders in Congress, each has been signed by a Republican governor.

The debate over New York's new law, a broad set of mandates related to women's health that will be signed by Gov. George E. Pataki (R), was particularly long and contentious. Similar measures had been approved by the Assembly the four prior years but blocked in the Senate, first by inaction and later by the Senate's insistence on a broadly worded exemption for employers claiming an opposition to contraception on the basis of their religious beliefs, a provision that the Assembly opposed. (Major disputes over coinsurance for breast and cervical cancer screening also contributed to the delays.) Lawmakers broke the "refusal clause" standoff in June, compromising on a provision identical to one included in California's 1999 law that narrowly defines a religious employer as one that has as its mission the inculcation of religious values, that primarily employs and serves people who share its religious tenets, and that falls under a U.S. tax code provision that applies to churches, church auxiliaries and religious orders. Under the New York law, employees of exempted entities may purchase contraceptive coverage directly from the employer's insurer.

When news broke of the compromise, the state's Catholic Conference announced that it might challenge the new law in court, describing it as an attack on the Catholic Church and a violation of First Amendment principles. In particular, the conference lamented the fact that the law's exemption would not apply to Catholic hospitals, nursing homes, schools and charitable agencies. In 2001, a state appeals court ruled against a challenge to California's exemption, finding that the state had a right not only to define the exempt group as it chose but also to have passed a law without any exemption. The case is currently before California's supreme court.

Arizona Gov. Jane Dee Hull (R) signed her state's law in April, despite reservations over its narrow refusal clause that also had been modeled on California's. The Arizona law is notable for another feature, duplicated only in Missouri's 2001 law: It prevents religious employers from discriminating against enrollees who find another way to purchase contraceptives. Massachusetts's new law, signed in March by acting governor Jane Swift (R), includes a refusal clause based on the U.S. tax code that would exempt churches, parochial schools, and "qualified church-controlled organizations."

The 20 states mandating contraceptive coverage account for almost half of the nation's population. State law, however, does not apply to employers that self-insure, and nearly half of workers and dependents with employer-sponsored insurance are in self-insured plans. Legislation pending in Congress, the Equity in Prescription Insurance and Contraceptive Coverage Act, would apply to all types of private-sector health insurance plans ("Federal Law Urged As Culmination of Contraceptive Insurance Coverage Campaign," *TGR,* October 2001, page 10).—*A. Sonfield*

STATE REQUIRING PRIVATE-SECTOR INSURANCE COVERAGE OF PRESCRIPTION CONTRACEPTIVES

1998	**2000**
Maryland	Delaware
1999	Iowa
California	Rhode Island
Connecticut	**2001**
Georgia	Missouri
Hawaii	New Mexico
Maine	Texas
Nevada	Washington
New Hampshire	**2002**
North Carolina	Arizona*
Vermont	Massachusetts*
	New York*

**Effective January 2003*

Michigan Breaks New Ground in Restricting Family Planning Funds

With varying degrees of success over the past 25 years, antiabortion state and federal lawmakers have advocated a range of restrictions designed to keep public funds for family planning from organizations that have anything to do with abortion. A new chapter in this saga began in May, when Michigan Gov. John Engler (R) signed into law a measure that takes the inventive tact of creating a priority system for distributing family planning funds.

Existing Michigan law, enacted annually since 1994 as part of the appropriations process, already prohibits state pregnancy prevention funds from being "used to provide abortion counseling, referrals, or services." The newly enacted law, which becomes effective next spring, goes well beyond this prohibition; it establishes a funding formula for state as well as federal Title X family planning grants that punishes organizations for their privately supported abortion-related activities. In essence, organizations are given a

"demerit" for engaging in any one of three abortion-related activities, and groups with the fewest demerits are to be awarded the grants. The offending activities are performing abortions, except to save a pregnant woman's life; providing referrals for abortion; or maintaining in writing that "abortion is considered part of a continuum of family planning or reproductive health services."

The new law does include a few caveats. First, it allows a potential family planning grantee to be affiliated, without penalty, with an organization that engages in any of the demerit-worthy activities, as long as an acceptable "wall of separation" exists between the two entities. Second, any activities required by federal law as a condition for receiving federal funding are not to be counted against a potential grantee; this would include Title X's requirement that fund recipients provide a woman facing an unintended pregnancy with nondirective counseling about all of her legal medical options, as well as contact information for providers of these services on request. Finally, the law stipulates that grants must be awarded to ensure adequate availability across the state and that grantees must be determined by the state health department to be "capable of providing the quality and quantity of services required" at appropriate costs. How any of these caveats will play out may depend on the attitude of the state administration that will be elected into office this November.

Over the past decade, five other states—Colorado, Missouri, Ohio, Pennsylvania and Wisconsin—have adopted policies that directly prohibit recipients of public family planning funds from performing certain abortion-related activities ("Efforts Renew to Deny Family Planning Funds to Agencies That Offer Abortions," *TGR,* February 2002, page 4). Advocates of Michigan's new priority system hope that by merely putting some potential grantees at a disadvantage in receiving funding, rather than flat-out declaring them ineligible because of their abortion-related activities, the new law will be met with less resistance and be better able to withstand possible court challenges. Challenges in Colorado and Missouri, for example, have lasted years. Already, the priority system is being looked to as a model in other states. But while the Michigan approach may be somewhat more subtle than those taken by other states, its goals are clear: to convey to the public the message that organizations involved in legal and medically appropriate abortion-related activities are somehow unfit—or at least, less fit than those not so involved—to receive public funds and, of course, to actually deny them the funds if they refuse to change their ways.—*A. Sonfield and E. Nash*