Thanks very
much for lending
this to me.
Meghan

ABORTION

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

DEC 23 1993

MEMORANDUM TO CHRISTINE VARNEY

From: Kevin Thurm

Re: Implementation of the new Hyde Amendment

Attached for your consideration and circulation is a memo to Carol Rasco concerning the Department's plan for implementing the new Hyde Amendment.

We are attempting to provide states with written notice before December 31, 1993 (although we are reaching out by phone to those states which will need to act most quickly).

If you have any questions, please do not hesitate to contact me either in the office (690-6133) or at home (337-8114).

My best wishes for a happy holiday and a happy and healthy new year.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

DEC 23 1993

MEMORANDUM

TO: Carol Rasco
Assistant to the President
for Domestic Policy

FROM: Kevin Thurm

SUBJECT: Implementation of the new Hyde Amendment

I write to inform you of the Department's plan for implementing the new Hyde Amendment.

In enacting this year's appropriations bill for HHS, Congress changed the scope of the Hyde Amendment. That provision now states:

> None of the funds appropriated under this Act shall be expended for any abortion, except when it is made known to the Federal entity or official to which funds are appropriated under this Act that such procedure is necessary to save the life of the mother or that the pregnancy is the result of an act of rape or incest.

The change with the greatest political significance is the addition of pregnancies that are "the result of an act of rape or incest" to the excepted category. The Department must now issue guidance to the States as to how this new language will be implemented and interpreted. Attached is a copy of the letter the Department proposes to send.

As you can see from the dates referenced in the draft letter, time is of the essence. A number of States will need to submit amendments to their existing state plans by December 31 in order to secure reimbursement for abortions performed during the first quarter of FY 1994. HCFA staff have begun informally reminding states by telephone of this deadline, but we still need to issue a letter before the 31st.

The decision by Congress to add coverage for abortions where the pregnancy results from rape or incest raises two questions answered by the attached letter:

- First, how does the category of rape and incest relate to the general principle under Medicaid that state coverage of physician services is mandatory only where those services are medically necessary?

  We believe that Congress intended by its language to make all abortions of pregnancies resulting from rape and incest medically necessary in light of psychological as well as physical factors. This is evident from the text of the Hyde Amendment, which lists these abortions immediately following the category of "necessary to save the life of the mother," a category as to which medical necessity is obvious. The history of Congressional debate also indicates concerns that women who are the victims of rape or incest suffer or may suffer serious psychological harm from that experience, harm that would be considerably exacerbated if they were forced to carry a resulting pregnancy to term. Thus, the Department interprets this category of excepted abortions in the same way as the first category and treats them as satisfying the general requirement of medically necessary.

- Second, to what extent, if any, may States require victims of rape and incest report those crimes to law enforcement or other agencies as a condition for Medicaid reimbursement?

  Several versions of the Hyde Amendment from the late 1970s included requirements that a victim report rape or incest within a certain amount of time to certain designated authorities, usually law enforcement agencies. This year's version of the Hyde Amendment, the first to include a rape or incest exception since the 1970s, does not include any form of a reporting requirement. In the intervening years, however, several states have elected to cover abortions of pregnancies resulting from rape or incest with their own funds, and some have imposed their own reporting requirements. These state-level requirements vary in their details from state to state.

  The Department has elected to allow, but not require, States to impose reasonable reporting or documentation requirements, in order to assure that the exception for rape and incest abortions is not abused. Where such requirements exist or should a State now elect to impose such requirements, however, the letter requires that States allow reimbursement if the treating physician certifies that the woman was unable for physical or psychological health reasons to comply with the requirement. This approach strikes a balance that will permit States that have such requirements to retain them and will not place the

Department in the position of forcing absolute uniformity among all such requirements. However, it also insures that a reporting requirement cannot be used to bar coverage when insisting on compliance would be contrary to the general principle of covering medically necessary services.

Also attached to this memorandum is the set of questions and answers that DHHS staff will use in responding to any inquiries from the press or public at the time the letter is distributed.

If you have any questions, please do not hestitate to contact me.

Attachments

cc: Christine Varney

DRAFT

Dear State Medicaid Director:

The purpose of this letter is to notify you about a recent Congressionally enacted revision to the "Hyde Amendment" which affects the Medicaid program and to tell you how this revision in the law is to be implemented.

Effective October 1, 1993, as part of P.L. 103-112, the Health and Human Services Appropriation bill, Congress passed a revision of the Hyde Amendment pertaining to Federal funding of abortions under the Medicaid program. As enacted, the provision states:

> None of the funds appropriated under this Act shall be expended for any abortion except when it is made known to the Federal entity or official to which funds are appropriated under this Act that such procedure is necessary to save the life of the mother or that the pregnancy is the result of an act of rape or incest.

Thus, Federal funding (FFP) is now available for abortions performed to save the life of the mother or to terminate pregnancies resulting from rape or incest when the claim for such an abortion is paid by the State on or after October 1, 1993. Please note that it is the date that the State pays the claim and not the date of the service which determines the availability of FFP.

In order to implement this provision of the law, we are requesting that beginning with the first Quarterly Expenditure Report (HCFA-64) for FY 94 in January, States submit to the HCFA regional office a form certifying the number of abortions for which FFP is being claimed. The form should outline the number of abortions performed to save the life of the mother, the number performed for a pregnancy resulting from an act of rape and the number performed for a pregnancy resulting from an act of incest. This certification should be submitted to the regional office on a quarterly basis with the completed HCFA-64.

Current regulations at 42 CFR 441.203 and 441.206 require that before FFP can be made available, the State must obtain a signed physician's certification that, based on the professional judgment of the physician, the abortion was necessary because "the life of the mother would be endangered if the fetus were

carried to term." Because the language of the current Hyde Amendment differs somewhat from its predecessors, the State must change the wording of the physician's certification to comport with the current statutory language. With regard to this portion of the Hyde Amendment, the new legislative language, "to save the life of the mother," has essentially the same meaning as the previous legislation.

As with all other mandatory medical services for which Federal funding is available, States are required to cover abortions that are medically necessary. By definition, abortions that are necessary to save the life of the mother are medically necessary. In addition, Congress this year added abortions for pregnancies resulting from rape and incest to the category of medically necessary abortions for which funding is provided. Based on the language of this year's Hyde Amendment and on the history of Congressional debate about the circumstances of victims of rape and incest, we believe that this change in the text of the Hyde Amendment signifies Congressional intent that abortions of pregnancies resulting from rape or incest are medically necessary in light of both medical and psychological health factors. Therefore, abortions resulting from rape or incest should be considered to fall within the scope of services that are medically necessary.

The definition of rape and incest should be determined in accordance with each State's own law. States may impose reasonable reporting or documentation requirements on recipients or providers, as may be necessary to assure themselves that an abortion was for the purpose of terminating a pregnancy caused by an act of rape or incest. States may not impose reporting or documentation requirements that deny or impede coverage for abortions where pregnancies result from rape or incest. To insure that reporting requirements do not prevent or impede coverage for covered abortions, any such reporting requirement must be waived and the procedure considered to be reimbursable if the treating physician certifies that in his or her professional opinion, the patient was unable, for physical or psychological reasons, to comply with the requirement.

States which have State Plan language more restrictive than that provided for under the revised Hyde Amendment may qualify for Federal funding for the first quarter of FY 94 if they submit approvable State Plan language changes by December 31, 1993.

By March 31, 1994, all States must ensure that their State Plans do not contain language that precludes FFP for abortions that are performed to save the life of the mother or to terminate pregnancies resulting from rape or incest.

As you know, it is necessary for States to adhere to all conditions for Federal Medicaid funding. As part of its ongoing State assessment and audit programs, HCFA may include reviews of

abortion claims, if necessary, to assure compliance with these conditions.

Please call my office if you have any questions about this matter.

Sincerely yours,

Sally K. Richardson

cc: All Regional Administrators

DRAFT
12/22/93
3:30 p.m.

MEDICAID ABORTION POLICY CONCERNING VICTIMS OF RAPE OR INCEST

1. Q. Since the Hyde Amendment has always been viewed as legislation restricting the variety of abortion cases which can qualify for Federal funding, why does the Administration believe that this language now dictates the variety of abortion cases which States must pay for?

   A. It is our interpretation that the Congressional intent of the 1993 Hyde Amendment language is to assure that poor women whose lives are endangered or who are victims of rape or incest will have the financial support of the Medicaid program if they choose to have an abortion.

2. Q. Your letter refers to payment for abortions in the context of "mandatory medical services" in Medicaid. What specific services are being addressed here?

   A. Inpatient and outpatient hospital services, physician services, rural health clinic (RHC) services, and Federally Qualified Health Center (FQHC) services.

3. Q. Are there any circumstances in which States will not be required to pay for abortions for cases of rape, incest or life endangerment?

   A. States will be required to pay for all such abortions unless the abortion is billed by the providers as an optional Medicaid benefit. For example, abortions billed as clinic services in clinics that are not certified as RHC's or FQHC's would not have to be paid for by a State. However, if a State chooses to pay for such abortions, Federal matching funds would be available.

4. Q. Your letter has been issued quite late in December, considering that it instructs States to submit approvable State plan changes by December 31. Why is this?

   A. First, it's important to recognize that only a few States have to submit State plan changes. Those States with State plans which are silent on abortion coverage limitations or which tie

their limitations to the statutory availability of Federal funding for abortions do not have to revise their State plans. For the States which do need to change their State plans, we believe that they would have very few, if any Medicaid abortions performed for victims of rape or incest in the October - December quarter. States are most likely to submit a State plan change by December 31 if they have substantial Federal funding at stake. While we don't believe this will be an issue for this one quarter, we wanted to be sure that States were advised that they had that opportunity.

5. Q. What methods will you use to ensure that only the cases described in the new Hyde Amendment language will be paid for with Federal funds?

A. HCFA is asking that the States develop their own methods to assure that all claims for Federal funding qualify under the Hyde Amendment requirements. HCFA will then use its audit authority to the extent necessary to review particular claims for Federal matching.

6. Q. When your letter indicates that States are required to cover medically necessary abortions for victims of rape and incest, are you saying that even if State law prescribes payments for abortions, the State must pay anyway through its Medicaid program?

A. Yes. We believe this is consistent with the requirement of the Federal law.

7. Q. Do you have any estimates of how many additional abortions will be paid for by Medicaid as a result of this policy?

A. That is a very difficult estimate to make. Many States already pay for all Medicaid beneficiaries' abortions with 100% State funds and do not report those numbers. The States are likely to begin submitting these claims for the Federal funding share. This means there is no known number of current abortions upon which to base an estimate. An educated guess would range between one and a few thousand.

8. Q. How many more abortions are going to be performed because of this policy?

A. Again, that's a hard question to answer, but since many States are already paying claims for this service, we don't believe the numbers will be significant.

9. Q. What do you plan to do if a State does not comply with this policy?

   A. The Federal government has general authority in the area of State compliance. We will address the use of that authority as it becomes necessary.

10. Q. What makes you think that physicians and beneficiaries won't abuse the latitude given on reporting for victims of rape or incest?

    A. We are not overturning any requirement that the physician or patient needs to report in accordance with State law. The latitude comes in waiving the timing of the report in an emergent situation.

11. Q. How would you define an emergency in this case?

    A. That is a judgment for the physician to make in light of the individual's mental and physical circumstances. We would not supersede that judgment.

"All the News That's Fit to Print"

The New York Times

Late Edition

VOL. CXLIII . . . No. 49,458 NEW YORK, MONDAY, DECEMBER 27, 1993 35 CENT

Kerrey Backs New Abortion Rule

Special to The New York Times

WASHINGTON, Dec. 26 — Senator Bob Kerrey of Nebraska said tonight that he did not consider the Clinton Administration's decision to require states to pay for some abortions for poor women to be a violation of assurances given to Congress.

Over the weekend, an abortion opponent, Douglas Johnson, the legislative director of National Right to Life, cited a letter by Senator Kerrey as proof that the Administration had gone back on its word that the states would maintain the right to keep abortion out of their Medicaid programs.

In September, Congress loosened the ban on Federal financing for abortions to allow the Government to pay for abortions for Medicaid recipients in cases of rape or incest as well as when the life of the pregnant woman is in danger. The Administration had sought to repeal the ban, the Hyde Amendment, named for Representative Henry Hyde of Illinois.

Bruce C. Vladeck, the official in charge of Medicaid and Medicare, said on Friday that the Administration was preparing regulations to require states to pay for such abortions, which would number about a thousand a year.

Mr. Johnson quoted Senator Kerrey in a letter to Metro Right to Life in Omaha as saying he had "received personal assurances that in the absence of the Hyde Amendment, states like Nebraska, which do not allow state funds to be used for abortions, would not be required to accept Federal funds for such procedures."

But Senator Kerrey said tonight in a telephone interview that the letter concerned the amendment's repeal. "The question was asked whether states would be able to impose additional restrictions," he said. "The Administration said it would not coerce states to pay for abortions in all circumstances."

Senator Kerrey, who supported the change in the Hyde amendment but opposed its repeal, said he favored the new policy. "It's in fact in keeping with what an awful lot of supporters of the Hyde amendment were actually advocating," he said.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of the General Counsel
Washington, D.C. 20201

(202) 690-7780
Fax: 690-7998

MEMORANDUM

To: Kevin Thurm, Chief of Staff

From: Nan D. Hunter, Deputy General Counsel

Date: 27 December 1993

Re: Effect of the New Hyde Amendment

This memorandum explains the principles of law governing Medicaid that were the basis for the Department's decision to notify State Medicaid directors that some existing State policies may be out of compliance with the new Hyde Amendment.

Why is State coverage of medically necessary abortions mandatory?

The Medicaid program is a joint federal-state program under which the federal government provides funds to reimburse States for the cost of medical care for poor people. A State may elect not to participate at all in the Medicaid program, but once it elects to participate it must comply with the requirements of federal law.

Under the Medicaid statute, services may be either mandatory, in which case the state must provide them and pay the state share for them, or optional. By law, medically necessary physician services are mandatory. 42 U.S.C. Sec. 1396a(10)(a). States have the discretion to impose reasonable coverage limits on the amount, duration, or scope of these services (e.g., a State could limit the number of physician visits per year). 42 C.F.R. 220.230(b), (d). But a State cannot limit coverage of a mandatory service "solely because of the diagnosis, type of illness or condition." 42 C.F.R. 440.230(c). Thus, a State that elects to participate in Medicaid may not limit medically necessary services related to pregnancy. A participating State has no choice but to cover its portion of the costs of medically necessary physician services.

Under that statutory scheme, but for the Hyde Amendment, all abortions that are medically necessary and performed by a physician would be mandatory services. Under pre-1981 versions of the Hyde Amendment, a series of lawsuits were brought

to challenge state funding limits that were more restrictive than the then-current version of Hyde. In those cases, every U.S. Court of Appeals that considered the issue ruled that the federal statute, as modified by Hyde, mandated coverage of those abortions for which federal reimbursement was provided. Roe v. Casey, 623 F.2d 829 (3d Cir. 1980); Hodgson v. Board of County Comm'rs, 614 F.2d 601 (8th Cir. 1980); Zbaraz v. Quern, 596 F.2d 196 (7th Cir. 1979), cert. denied, 448 U.S. 907 (1980); Preterm v. Dukakis, 591 F.2d 121 (1st Cir.), cert. denied, 441 U.S. 952 (1979). Stated otherwise, if a State law was more restrictive than federal law regarding medically necessary abortions, the federal law had to prevail.

These rulings were based on the principle that state laws that impose more restrictive conditions on eligibility for a federal-state program are invalid because they conflict with federal law. Under the Supremacy Clause of the Constitution, federal law pre-empts state law when there is a direct conflict. This principle is true regardless of whether the state law exists in the form of a state statute or a state constitutional provision. Article VI, cl. 2 of the Constitution states: "This Constitution and the Laws of the United States which shall be made in pursuance thereof. . .shall be the supreme law of the land; and the judges in every State shall be bound thereby, any thing in the Constitution or Laws of any State to the contrary notwithstanding."

What is the impact of the change in language of the Hyde Amendment?

The Hyde Amendment prohibits the use of federal funds for abortions, with certain exceptions. In enacting this year's appropriations bill for HHS, Congress changed the scope of the Hyde Amendment by providing coverage for abortions of pregnancies resulting from rape or incest. The Hyde Amendment now states:

> None of the funds appropriated under this Act shall be expended for any abortion except when it is made known to the Federal entity or official to which funds are appropriated under this Act that such procedure is necessary to save the life of the mother or that the pregnancy is the result of an act of rape or incest.

When Congress lifted the prohibition on funding for abortions of pregnancies resulting from rape or incest, those abortions then became subject to the same standards for medically necessary physician services as any other procedure. Thus, when a pregnancy results from rape or incest, coverage by the State of a medically necessary abortion is mandatory.

The decision by Congress to restore funding for abortions when pregnancies result from rape and incest implicitly determines that these abortions fall within the rubric of medically necessary services, in light of psychological as well as physical

factors. This is evident from the text of the Hyde Amendment, which lists these abortions immediately following the category of "necessary to save the life of the mother," a category as to which medical necessity is obvious. In addition, the long history of Congressional consideration of this topic also reflects concern that women who are the victims of rape or incest suffer serious psychological harm from that experience, harm that would be greatly exacerbated if they were forced to carry a resulting pregnancy to term. Under existing Medicaid policy, medically necessary services can include those related to mental health, as well as to physical health. For these reasons, the Department interprets this category of excepted abortions in the same way as the first category and treats them as satisfying the general requirement of medically necessary.

Can States impose reporting requirements?

The second question raised by the addition of the new language to the Hyde Amendment concerning rape and incest is, to what extent, if any, may States require that victims of rape and incest report those crimes to law enforcement or other agencies as a condition for Medicaid reimbursement?

Several versions of the Hyde Amendment from the late 1970s included requirements that a victim report rape or incest within a certain amount of time to certain designated authorities, usually law enforcement agencies. This year's version of the Hyde Amendment, the first to include a rape or incest exception since the 1970s, does not include any form of a reporting requirement. In the intervening years, however, several states have elected to cover abortions of pregnancies resulting from rape or incest with their own funds, and some have imposed their own reporting requirements. These state-level requirements vary in their details from state to state.

The Department has elected to allow, but not require, States to impose reasonable reporting or documentation requirements, in order to accommodate State law to the extent consistent with the Medicaid statute. Where such requirements exist or should a State now elect to impose such requirements, the Department will announce that States must allow reimbursement if the treating physician certifies that the woman was unable for physical or psychological health reasons to comply with the requirement. This approach strikes a balance that will permit States that have such requirements to retain them and will not place the Department in the position of forcing absolute uniformity among all such requirements. However, it also insures that a reporting requirement cannot be used to bar coverage, when insisting on compliance would be contrary to the general principle of covering medically necessary services.

(3)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of the General Counsel
Washington, D.C. 20201

(202) 690-7780

MEMORANDUM

To: Bill Galston

From: Nan D. Hunter, Deputy General Counsel

Date: 20 September 1993

Re: Status of abortion law without a Hyde amendment

Following is a memorandum that explains the impact of the absence of a Hyde-like amendment on the states' obligation to fund medically necessary abortion services as part of the Medicaid program.

It is also true, as I said on the phone, that state laws of general applicability would be unaffected by the absence of a Hyde amendment. The validity of those laws -- such as parental notification or waiting period requirements -- would be analyzed under the standard adopted by the Supreme Court in Planned Parenthood v. Casey, 112 S. Ct. 2791 (1992), in which the Court held that state regulation of abortion would be upheld unless it imposed an undue burden on the woman's decision whether to terminate a pregnancy.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

The General Counsel
Washington, D.C. 20201

To: The Secretary

From: Nan D. Hunter
Deputy General Counsel

Re: Briefing Materials
Secretary's Meeting with Abortion Rights Groups
Tuesday, July 20, 1993 - 3:30 p.m.

Purpose

The purpose of this meeting is to discuss with leaders of abortion rights groups the Administration's efforts to enact legislation that will permit public funding of abortions for poor women under the Medicaid program.

Background of the Hyde Amendment

Since September, 1976, Congress has prohibited the use of federal funds to reimburse the cost of abortions under the Medicaid program, except in certain specified circumstances. This funding restriction is commonly known as the Hyde Amendment, after its sponsor, Rep. Henry Hyde. The exact wording of the Hyde Amendment has varied from year to year. A compilation of the text of each version of the Hyde Amendment since 1976 is attached as Appendix 1. The most recent wording, which has been the same since fiscal year 1984, is as follows:

> None of the funds contained in this Act shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term.

In some years prior to 1984, the restriction contained other exceptions, including for "medical procedures necessary for the victims of rape or incest" and "in those instances where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term when so determined by two physicians."

The effect of the Hyde Amendment has been to exempt medically necessary abortions from the general rule that a State Medicaid plan must cover all physician or hospital services. Title XIX of the Social Security Act- the Medicaid statute - mandates the coverage of certain individuals and certain services. Section 1902(a)(10)(A) makes physician and hospital services (inpatient and outpatient) mandatory for the categorically needy. States have greater flexibility in coverage of services for medically needy persons (individuals with somewhat greater income and resources), but under the system of selecting those services, all states

include physician and hospital services as required services for the medically needy as well, according to HCFA.

Regulations sharply curtail the State's discretion to disallow mandatory or required services. A State Medicaid program

> may not arbitrarily deny or reduce the amount, duration, or scope of a required service . . . solely because of the diagnosis, type of illness or condition.

42 C.F.R. 440.230(c). Although some limitations on required services are permitted (e.g., a cap on the number of physician visits), HCFA does not permit limitations that are diagnosis-specific.

In Harris v. McRae, 448 U.S. 297 (1980), the Supreme Court upheld the Hyde Amendment against a constitutional challenge, and also ruled that the states themselves were not obligated to independently cover medically necessary abortions in the absence of federal funding. In a context without a Hyde-like restriction in place, however, the Supreme Court noted that "serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage." Beal v. Doe, 432 U.S. 438, 444 (1977).

Thus, if a version of the Hyde Amendment were not in place, states would be obligated to provide funding for medically necessary abortions in order to comply with the statute. Absent federal legislation incorporating a restriction of some sort, states would be required under the statute to include abortions along with other medically necessary services. This conclusion is based on the foregoing regulations and on the pre-Hyde practice, which was that medically necessary abortions were covered under Medicaid.

In addition to AFDC recipients and persons otherwise eligible for Medicaid-funded services, pregnant women with incomes up to 133 per cent - and, if a state elects, up to 185 per cent - of the poverty level became eligible in 1986 to receive pregnancy-related services under Medicaid. Pregnancy-related services are defined as "those services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman having been pregnant. These include, but are not limited to, prenatal care, delivery, postpartum care, and family planning services." 42 C.F.R. 440.210. Because the Hyde Amendment has been in effect since the beginning of funding for pregnancy-related services, there have been no regulations adopted, nor any court challenges, to determine the question of whether states would be mandated by this statute to cover medically necessary abortions as part of the scope of "pregnancy-related services."

COVERAGE FOR REPRODUCTIVE AND PREVENTIVE SERVICES

IN

THE MAJOR HEALTH REFORM PROPOSALS AND MEDICAID

Prepared by the
Women's Research and Education Institute
January 1994

Funded by the Kaiser Family Foundation as part of the Kaiser Health Reform Project

W·R·E·I

1700 18th Street, NW #400
Washington, DC 20009
(202) 328-7070

COVERAGE FOR REPRODUCTIVE AND PREVENTIVE SERVICES IN THE MAJOR HEALTH REFORM PROPOSALS AND MEDICAID*

	McDermott	Clinton	Chafee	Cooper	Medicaid
OVERVIEW	Universal health coverage through government-financed, tax-based, single-payer insurance system. Private health insurance would be virtually eliminated.	Employers would pay at least 80% of the premium for full-time workers (and a pro-rated share for some part-time workers) and their dependents. Other persons would buy insurance through newly created health insurance purchasing alliances. Universal coverage by 1997.	Persons not covered through an employer-plan would be required to buy insurance. Universal coverage to be fully phased in by 2000 if savings become available.	Small employers, employees, and nonworkers would be guaranteed the opportunity to buy insurance through health insurance purchasing cooperatives.	Eligibility varies by state, but beneficiaries generally must have low incomes and few financial resources, or very high medical expenses.
PREMIUM SUBSIDIES	Not applicable.	Premiums fully subsidized for persons on AFDC or SSI, or making $1000 or less a year; partially subsidized (sliding scale) for those with incomes between $1000 a year and 150% of poverty.	If savings become available, persons below 90% of poverty would get vouchers covering full costs by 1997; by 2005, such vouchers would go to persons at or below 100% of poverty. There would be assistance on a sliding scale to persons up to 240% of poverty.	Premiums fully subsidized for persons at or below 100% of poverty, partially subsidized (sliding scale) for persons between 100% and 200% of poverty.	Beneficiaries pay no premiums.
COST-SHARING					
Co-payments	Not required for preventive care or acute care benefits. Co-payments would be required for other services.	†**Low Cost Sharing** plan: $10-$25, depending on service, but no co-payment for clinical preventive services, including prenatal care. $10 co-payment for family planning and pregnancy services. ‡**High Cost Sharing** plan: 20% for most services but no co-payment for clinical preventive services, including prenatal care.	Not required for certain preventive services (services not yet specified). Required for other services.	Not required for preventive services (services not yet specified). Required for other services.	Some states collect co-payments for acute care benefits.
Deductibles	None for preventive care or acute care services. Other services may require deductibles.	**Low Cost Sharing** plan: None. **High Cost Sharing** plan: Individual $200; Family $400. Separate $250 deductible for prescription drugs. No deductible for clinical preventive services, clinician visits, prenatal care, or one post-partum visit.	None for certain preventive services (services not yet specified). Other services may require deductibles.	None for preventive services. May be required for other services.	None.
Out-of-Pocket Stop Loss	Not applicable.	**Low and High Cost Sharing**: Individual $1,500; Family $3,000.	Not specified in proposal.	Not specified in proposal.	NA

*Proposals as of January 10, 1994.
‡High Cost Sharing would be a fee-for-service system.
†Low Cost Sharing would be through a managed care network.
NA = Information not available from Medicaid Source Book.

	McDermott	Clinton	Chafee	Cooper	Medicaid
BENEFITS **Overview**	All medically necessary services including standard acute care, long-term care, preventive services, mental health, substance abuse treatment, prescription drugs, and some dental services.	Medically necessary or appropriate services including standard acute care, preventive services, prescription drugs, mental health, in-home care, and some dental. Long-term care services not included in basic package.	Medically necessary services including standard acute care benefit package, prescription drugs, preventive services, limited mental health and substance abuse treatment services. "Benefits Commission" to clarify benefit terms.	A "National Health Board" would establish a uniform benefits package of medically appropriate benefits which would, at minimum, offer standard acute care.	Medically necessary services including standard acute care, nursing home care, preventive services, prescription drugs, and home health services.
Clinical Preventive and Screening Services **Clinician Visits**	Frequency of benefit to be determined by a "National Health Board".	A total of 6 visits between 6th and 20th birthdays; age 20 through 39, one visit every 3 years; age 40 through 64, one visit every 2 years; age 65 and over, one visit annually. (Additional visits would be subject to the cost-sharing requirements of the individual's plan.)	Standard package would cover preventive services; the "Health Care Standards Benefits Commission" would clarify terms.	Benefit to be determined by a "National Health Board".	Covered.
Mammograms	Frequency of benefit to be determined by a "National Health Board".	Mammograms every 2 years for women over age 50 and more frequent screening for women of any age at risk for breast cancer (under guidelines set by a "National Health Board"). (More frequent screening that is medically necessary or appropriate would be subject to the cost-sharing requirements of the individual's plan.)	Standard package would cover preventive services; the "Health Care Standards Benefits Commission" would clarify terms.	Benefit to be determined by a "National Health Board."	43 states and the District of Columbia cover mammography screening.
Pap Smears	Frequency of benefit to be determined by a "National Health Board".	Every 3 years for women under 40, every two years for women age 40-64. More frequent screening available to women at risk of cervical cancer. After age 65, Pap smears are fully covered only if patient is at risk for cervical cancer. For all age groups, annual screening is covered for 3 years following an abnormal Pap smear. (More frequent screening that is medically necessary or appropriate would be subject to the cost-sharing requirements of the individual's plan.)	Standard package would cover preventive services; a "Health Care Standards Benefits Commission" would clarify terms.	Benefit to be determined by a "National Health Board".	50 states and the District of Columbia cover Pap smears and follow-up services for an abnormal Pap smear.
Sexually Transmitted Diseases (STDS)	Not specified in benefit package.	Annual chlamydia/gonorrhea screening for women of childbearing age (under 50) who are at risk for STDs that can affect fertility.	Not specified in benefit package.	Not specified in benefit package.	NA

NA = Information not available from Medicaid Source Book.

	McDermott	Clinton	Chafee	Cooper	Medicaid
BENEFITS continued					
Reproductive/Pregnancy-Related					
Family Planning Services (except prescription contraceptives)	Frequency of benefit to be determined by a "National Health Board".	Yes, but subject to a co-payment (20% of cost or $10, depending on individual's plan.)	A "Health Care Standards Benefits Commission" would determine whether these services would be covered.	A "National Health Board" would determine whether these services would be covered.	Yes.
Outpatient Coverage for Prescription Contraceptives	An "Advisory Committee on Prescription Drugs" would determine which drugs would be covered.	Yes, but subject to $250 deductible and a co-payment of $5.	Prescription drugs have not been specified.	A "National Health Board" would determine whether this benefit would be covered.	Yes.
Prenatal and Post-Partum	Frequency of benefit to be determined by a "Preventive Services Task Force".	Prenatal care and one post-partum visit fully covered. Other services would be subject to a co-payment (20% of cost or $10, depending on individual's plan.)	A "Health Care Standards Benefits Commission" would determine whether these services would be covered.	A "National Health Board" would determine whether this benefit would be covered.	Yes.
Abortion	Not specified in benefit package.	Yes, but subject to a co-payment (20% of cost or $10, depending on individual's plan.)	A "Health Care Standards Benefits Commission" would determine whether these services would be covered.	A "National Health Board" would determine whether this benefit would be covered.	13 states allow state funding for all abortions. On December 28, 1993, the Clinton administration directed all states to provide Medicaid coverage for abortions in cases of rape or incest, or if needed to save the life of the mother.
Infertility Services	Not specified in benefit package.	Limited coverage; in vitro fertilization not covered.	A "Health Care Standards Benefits Commission" would determine whether these services would be covered.	A "National Health Board" would determine whether this benefit would be covered.	Limited coverage.
FATE OF MEDICAID	Would be folded into the new system.	Would be retained for long-term nursing care. Persons on AFDC or SSI would get vouchers with which to purchase insurance through health alliances. Medicaid recipients not on AFDC or SSI would qualify for subsidies allowing them to obtain coverage through a health alliance.	Remains as is; spending caps would be placed on the program.	Medicaid acute care patients would be shifted to cooperatives; government would cover costs. Medicaid long-term care costs would be gradually assumed by the states.	

COVERAGE FOR REPRODUCTIVE AND PREVENTIVE SERVICES

IN

THE MAJOR HEALTH REFORM PROPOSALS AND MEDICAID

Prepared by the
Women's Research and Education Institute
January 1994

Funded by the Kaiser Family Foundation as part of the Kaiser Health Reform Project

W·R·E·I

1700 18th Street, NW #400
Washington, DC 20009
(202) 328-7070

	McDermott	Clinton	Chafee	Cooper	Medicaid
BENEFITS **Overview**	All medically necessary services including standard acute care, long-term care, preventive services, mental health, substance abuse treatment, prescription drugs, and some dental services.	Medically necessary or appropriate services including standard acute care, preventive services, prescription drugs, mental health, in-home care, and some dental. Long-term care services not included in basic package.	Medically necessary services including standard acute care benefit package, prescription drugs, preventive services, limited mental health and substance abuse treatment services. "Benefits Commission" to clarify benefit terms.	A "National Health Board" would establish a uniform benefits package of medically appropriate benefits which would, at minimum, offer standard acute care.	Medically necessary services including standard acute care, nursing home care, preventive services, prescription drugs, and home health services.
Clinical Preventive and Screening Services **Clinician Visits**	Frequency of benefit to be determined by a "National Health Board".	A total of 6 visits between 6th and 20th birthdays; age 20 through 39, one visit every 3 years; age 40 through 64, one visit every 2 years; age 65 and over, one visit annually. (Additional visits would be subject to the cost-sharing requirements of the individual's plan.)	Standard package would cover preventive services; the "Health Care Standards Benefits Commission" would clarify terms.	Benefit to be determined by a "National Health Board".	Covered.
Mammograms	Frequency of benefit to be determined by a "National Health Board".	Mammograms every 2 years for women over age 50 and more frequent screening for women of any age at risk for breast cancer (under guidelines set by a "National Health Board"). (More frequent screening that is medically necessary or appropriate would be subject to the cost-sharing requirements of the individual's plan.)	Standard package would cover preventive services; the "Health Care Standards Benefits Commission" would clarify terms.	Benefit to be determined by a "National Health Board."	43 states and the District of Columbia cover mammography screening.
Pap Smears	Frequency of benefit to be determined by a "National Health Board".	Every 3 years for women under 40, every two years for women age 40-64. More frequent screening available to women at risk of cervical cancer. After age 65, Pap smears are fully covered only if patient is at risk for cervical cancer. For all age groups, annual screening is covered for 3 years following an abnormal Pap smear. (More frequent screening that is medically necessary or appropriate would be subject to the cost-sharing requirements of the individual's plan.)	Standard package would cover preventive services; a "Health Care Standards Benefits Commission" would clarify terms.	Benefit to be determined by a "National Health Board".	50 states and the District of Columbia cover Pap smears and follow-up services for an abnormal Pap smear.
Sexually Transmitted Diseases (STDS)	Not specified in benefit package.	Annual chlamydia/gonorrhea screening for women of childbearing age (under 50) who are at risk for STDs that can affect fertility.	Not specified in benefit package.	Not specified in benefit package.	NA

NA = Information not available from Medicaid Source Book.

	McDermott	Clinton	Chafee	Cooper	Medicaid
BENEFITS continued					
Reproductive/Pregnancy-Related					
Family Planning Services (except prescription contraceptives)	Frequency of benefit to be determined by a "National Health Board".	Yes, but subject to a co-payment (20% of cost or $10, depending on individual's plan.)	A "Health Care Standards Benefits Commission" would determine whether these services would be covered.	A "National Health Board" would determine whether these services would be covered.	Yes.
Outpatient Coverage for Prescription Contraceptives	An "Advisory Committee on Prescription Drugs" would determine which drugs would be covered.	Yes, but subject to $250 deductible and a co-payment of $5.	Prescription drugs have not been specified.	A "National Health Board" would determine whether this benefit would be covered.	Yes.
Prenatal and Post-Partum	Frequency of benefit to be determined by a "Preventive Services Task Force".	Prenatal care and one post-partum visit fully covered. Other services would be subject to a co-payment (20% of cost or $10, depending on individual's plan.)	A "Health Care Standards Benefits Commission" would determine whether these services would be covered.	A "National Health Board" would determine whether this benefit would be covered.	Yes.
Abortion	Not specified in benefit package.	Yes, but subject to a co-payment (20% of cost or $10, depending on individual's plan.)	A "Health Care Standards Benefits Commission" would determine whether these services would be covered.	A "National Health Board" would determine whether this benefit would be covered.	13 states allow state funding for all abortions. On December 28, 1993, the Clinton administration directed all states to provide Medicaid coverage for abortions in cases of rape or incest, or if needed to save the life of the mother.
Infertility Services	Not specified in benefit package.	Limited coverage; in vitro fertilization not covered.	A "Health Care Standards Benefits Commission" would determine whether these services would be covered.	A "National Health Board" would determine whether this benefit would be covered.	Limited coverage.
FATE OF MEDICAID	Would be folded into the new system.	Would be retained for long-term nursing care. Persons on AFDC or SSI would get vouchers with which to purchase insurance through health alliances. Medicaid recipients not on AFDC or SSI would qualify for subsidies allowing them to obtain coverage through a health alliance.	Remains as is; spending caps would be placed on the program.	Medicaid acute care patients would be shifted to cooperatives; government would cover costs. Medicaid long-term care costs would be gradually assumed by the states.	

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THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release June 29, 1994

REMARKS BY THE PRESIDENT
TO NATIONAL ACADEMY OF SCIENCES

The Benjamin Franklin Room
United States Department of State
Washington, D.C.

9:06 P.M. EDT

THE PRESIDENT: Thank you. Now, the next time someone asks me -- some irate, self-proclaimed expert in these matters -- (laughter) -- asks me, why in the wide world did you ever appoint Tim Wirth at the State Department, I'll say, well, I had to get Ted Turner up off the floor. (Laughter.) Didn't have much to do with public policy; couldn't stand to see a man with all that energy prone for the rest of his life. (Laughter) Seemed like an incalculable waste of human potential. (Laughter.)

Thank you. Thank you, Ted, and thank you, Jane. When I was down in Atlanta the other day to do the global press conference, which is one of the most exciting experiences I have had as the President or, indeed, in my entire public life, and I loved meeting all the journalists from around the world and trying to answer their questions and communicating with them. When it was over, I got a handwritten note from Jane Fonda that said, well, you did a pretty good job on that, but don't forget about population. (Laughter and applause.) It was more formal, more polite, but that is the distilled essence of the letter that I got. (Laughter.)

So for both of them, I thank them for being here, although I do believe being on a stream in Montana is a way of supporting sustainable development that all of us could appreciate.

I want to thank, also, Dr. Bruce Alberts and the staff at the National Academy of Sciences; the Shorenstein Barone Center of the Kennedy School, and the Pew Global Stewardship Initiative for this event. And I do want to say a special word of thanks to Tim Wirth. All of you who care passionately about this issue know how well he has done; what a great advocate he has been for bringing the world's attention to the kinds of challenges that will command all of us for decades to come. It's not always easy, and it's now almost become trite to say that anyone who wants to truly change things has to be willing to be misunderstood. And sometimes I think Tim is competing with me for first in line on that subject. (Laughter.) But the country is in your debt, sir, and we thank you very much. (Applause.)

I've been trying to prepare to go to the G-7 meeting in Naples. And I've been working on this organization for the last, well, year and a half -- as long as I've been in office -- to try to first get them to focus on global growth in the short run, about what we can do in our nations and together; and then to think about what the world will look like in the next century and what we must do. And I must tell you, I am of two minds. I am so happy and proud to be going there, basically to say that what we agreed to do is working; in the near-term, it is clearly working.

The United States has 40 percent of the gross domestic product of the G-7. But in the last year, we've had 75 percent of the growth, almost 100 percent of the jobs, twice the investment rate, twice the export increase rate, the highest rate of productivity growth. We've got the second lowest deficit; next year we'll have the lowest deficit of all of the G-7 countries. These things are heartening to me. And as a group, our economy is in the best shape it's been in in four years. There is a sense that we're working together, and that our nation is fortunate enough to lead the way.

But when you look at the long-run trends that are going on around the world -- you read articles like Robert Kaplan's article in The Atlantic a couple of months ago that some say it's too dour -- still, if you really look at what is going on, you could visualize a world in which a few million of us live in such opulence we could all be starring on nighttime soaps. And the rest of us look like we're in one of those Mel Gibson "Road Warrior" movies.

And I was so gripped by many things that were in that article, and by the more academic treatment of the same subject by Professor Homer Dixon. And I keep trying to imagine what it's going to be like to bring children into this world in this country, or that one, or the other. That is really what we are forced to come to grips with. And when I think about it, my mind starts bursting in those ways that some people say are undisciplined, but I think are productive. (Laughter and applause.)

If you look at the landscape of the future and you say, we have to strengthen the families of the globe; we have to encourage equitable and strong growth; we have to provide basic health care; we have to stop AIDS from spreading; we have to develop water supplies and improve agricultural yields and stem the flow of refugees and protect the environment, and on and on and on -- it gives you a headache. And of course, on that list, you have to say, if you look at the numbers, you must reduce the rate of population growth.

Tim was talking about Haiti. My daughter and I once were talking about Haiti a few months ago, and I was telling her about how her mother and I had gone to Haiti once many years ago, shortly after we married, and what sadness and hope I had seen there at the same time, and what had happened since then. And she said to me, I know all that, Dad, because I've seen aerial photographs from in space. And if you look at the island, you can see where the Dominican Republic ends and where Haiti begins. And there couldn't' be all that environmental destruction without all those other problems you talked about. It was a stunning thing from the perspective of an American schoolchild that sort of wraps all this up.

I say that to make this point: We have to be disciplined in saying, well, all right, how much time and how much money and how much energy have we got; and we have to order our priorities. But we cannot be naive enough to think that it is so easily to isolate one of these issues as opposed to another, that there is some silver bullet that solves the future of the world.

If you look at the rate at which natural resources are disappearing, and you look at the rate at which the gap between rich and poor is growing, if you look at the fact that the world's population has doubled since only 74 nations met in Rome 40 years ago, it is clear that we need a comprehensive approach to the world's future. We call it under the buzzword of sustainable development, I guess, but there is no way that we can approach tomorrow unless we at least are mindful of our common responsibilities in all these areas.

During the nine days of the upcoming Cairb conference, more than two million people will enter our world. More than two

million new babies will be born into a world in which one-third of our children are already hungry, two of every five people on Earth lack basic sanitation, and large parts of the world exist with only one doctor for every 35,000 or 40,000 people. Reversing these policies will require innovation and commitment and a determination to do what can be done over a long period of time, while all of us around the world are busy with our own business within our borders.

It will require us to be willing to think anew about the relationship of human development to what is going on in all of these nations; to cast aside a lot of our ideas in the past -- when it was always tempting to believe that there was one single thing we could do, some silver bullet, that would make everything all right.

To bring about shared prosperity, as Professor Homer Dixon has written, the nations of the world simply must move forward on many fronts at one time. Reducing population growth without providing economic opportunity won't work. Without education, it's hard to imagine how basic health care will ever take hold. Ignored, these challenges will continue to divide people from one another. We simply have to solve these problems together; both the problems together, and together as the people of the world.

I'm really proud of the fact that the G-7 has agreed to address some of these issues in a serious way this week in Naples. We're going to talk about what we can do within the G-7 to promote not just growth, but more jobs -- because a lot of the wealthy countries are finding they can't create jobs even when they grow their economy. And then, when they can't do that, they lose the constituency at home to engage the rest of the world.

We're going to talk about how we build an economic infrastructure for the 21st century. What's this new world trade organization that we create with GATT going to look like? And what should the World Bank and the IMF do? We're also going to talk about how we can help economies in transition, like the states of the former Soviet Union, and what we can do with the economies that are not in transition or, if anything, are going the wrong way, to address our common responsibilities.

This is quite a unique thing, really, for the world's advanced nations. And I'm quite pleased that, with all the economic problems that exist in many of these countries, they are willing to have a serious look at where we should be 10 or 20 years from now -- far beyond the election prospects of all the world leaders who will be there.

As we head for the Cairo conference, I think that same approach has to guide us. The policies we promote must be based on enduring values -- promoting stronger families, having more responsibility from individual citizens, respecting human rights, deepening the bonds of community. Here at home and around the globe, that's where the future lies, beginning with our families. When they're whole and they function, families nurture and care for us. They provide role models. They communicate values and enable people to live together in peace and to work together for common objectives. Therefore, that is the most important thing we can do.

Since the beginning of this administration, we have worked to promote policies that would permit families to grow in strength at home and abroad. I reversed the so-called Mexico City policy because I thought that doctors and medical workers around the world should be able to really work on family planning and provide a full range of family planning information. (Applause.)

Since then, we have increased by about 50 percent, at a very tough budget time, the Agency for International Development's budget for international family planning and support services. To

bolster families here at home, we passed a big increase in the earned income tax credit to help keep 15 million working families off welfare, out of poverty and in the work force. We increased Head Start availability and nutrition programs to hundreds of thousands of children; cracked down on delinquent child support payments; increased immunization funds so that we can increase by literally more than a million the number of children who are immunized.

We're working to reduce out-of-wedlock and teen births. Through the Family and Medical Leave Act, we're working to make it possible for people to be successful workers and successful parents -- a big issue everywhere in the world now, where more and more parents must work. In any society which forces people to choose, we are doomed to failure. If people have no option to work, and we all need people to continue to bear children, surely all of our parents must be successful workers, and our workers must be able to succeed as parents.

Our population policy is rooted in the idea that the family should be at the center of all of our objectives. Therefore, there must be a support for the concept of responsibility -- of parents to their children, of men and women to one another, and of our current generation to future generations.

Progress brings freedom; freedom requires more disciplined responsibility. And we must teach our young people to choose wisely, and tell them that their choices must include abstinence. Our policy has always been rooted in the ethical principles of compassion and justice and respect for human rights. We have supported every individual's dignity and worth. And we will continue to oppose and to condemn all forms of coercion in family planning. (Applause.)

Helping to translate these principles into reality is the charge that the Vice President will take to Cairo in September. No one is better suited to this task than he is. He has shown his commitment to these long-term challenges, and he has been thinking in large ways about them long before they were politically unpopular, or even the source of much current discussion.

In Cairo, we'll join the international community in pursuing a new plan of action to attack the population problem as part of the larger issue of sustainable development. At the top of our agenda will be active support for efforts to invest in the women of the world. (Applause.) Maybe over the long run, maybe the most important thing that Cairo policy will call for is that every nation make an effort to educate its children on an equal basis, to put an end to the widespread practice of withdrawing girls from school and forcing them to go to work before boys do.

To ensure that nations can develop at a more rapid pace, it will call on each of us to recognize women's work and development, and to engage them fully in the work force. It will help to give women the full rights of citizenship and to end discrimination which exists still nearly everywhere and slows progress wherever it exists.

At Cairo, the United States will also join the international community in launching new, high-quality, voluntary family planning and reproductive health programs. Our goal is to make these programs available to every citizen in the world by early in the next century. Parents must have the right to decide freely and responsibly the number and spacing of their children.

Now, I want to be clear about this. Contrary to some assertions, we do not support abortion as a method of family planning. We respect, however, the diversity of national laws, except we do oppose coercion wherever it exists. Our own policy in the United States is that this should be a matter of personal choice,

not public dictation. (Applause.) And as I have said many times, that abortion should be safe, legal and rare.

In other countries where it does exist, we believe safety is an important issue. And if you look at the mortality figures, it is hard to turn away from that issue. We also believe that providing women with the means to prevent unwanted pregnancy will do more than anything else to reduce abortion. (Applause.)

Finally, let me say, we must take to Cairo the same basic commitment to provide health care for every citizen of the world that we have brought to the public debate here in America. (Applause.) I must say that there is less disagreement among the representatives of the 174 countries going to Cairo than there is among the 535 members of Congress. (Laughter.) Maybe we can bring the spirit back home.

Experience shows that investing in maternal health, prenatal services, preventive care for children, does not only save lives, it eventually gives people the confidence they need to know that their children will survive. And that changes all kinds of attitudes that affect the way children are raised. Every country has committed itself to improving the health of women and children. And everyone that has really done that has seen a decline in population growth and a rise in prosperity.

The Cairo conference, therefore, can do a great deal to advance our vision of sustainable development and stabilized population growth, to help us fulfill a vision of a world of intact families in which every member is cherished; a world that has the wisdom and the strength to tackle challenges head on, instead of to talk about them and use words to divide people so they don't really address them; a world that will lead to equal opportunity and shared prosperity.

When President Roosevelt died in 1945, there was a typed manuscript of his last speech which was found with just a single sentence written in his own hand. This was the last sentence of the last speech that Franklin Roosevelt had written -- one that he never got to give. His handwritten sentence said, "The only limit to our realization of tomorrow will be our doubts of today. Let us move forward with strong and active faith." In the face of so many seemingly intractable problems, it is certainly tempting to let those doubts take control.

But I think those of you here tonight believe as I do that we can, instead, search for and find solutions that will help generations yet to come. President Roosevelt governed at a time when doubt was a luxury the American people could not afford. I say to you tonight, doubt is a luxury the world can no longer afford.

I commend you for your compassion and your commitment. I urge you to turn this faith into action and to help me to do my job to do the same.

Thank you very much.

END 9:36 P.M. EDT

File
Abortion

THE WHITE HOUSE

WASHINGTON

DELIVERED AUG 3 1 1995

MEMORANDUM TO THE PRESIDENT

FROM: ABNER MIKVA, PAT GRIFFIN, CAROL RASCO, GEORGE STEPHANOPOULOS

THROUGH: LEON PANETTA

CC: ALICE RIVLIN, ALEXIS HERMAN, MELANNE VERVEER

Earlier this summer, the House Judiciary Committee reported out (by a party-line vote, with three Democrats absent) a bill introduced by Congressman Canady (R-Fla.) known as the "Partial Birth Abortion Ban Act." The Office of Legal Counsel at DOJ believes the bill is "constitutionally flawed." Given your opposition to most post-viability abortions and the controversy surrounding the topic, we thought you should decide how to respond to this bill.

Background

As you know, Roe v. Wade and its progeny forbid significant restrictions upon abortion prior to viability but permit the government to ban post-viability abortions except those that protect maternal life or health. As governor, you signed a law making abortion illegal after the 25th week of pregnancy, with an exception for life and health (as well as one for rape or incest, in the case of minors).

The Canady bill criminalizes the conduct of any doctor who performs (but not of the mother who obtains) what is medically termed a "dilation and extraction" abortion. D & X abortions are usually performed only after 20 weeks of pregnancy. At least some doctors regard it as the safest method of late-term abortion under certain circumstances. The method involves bringing the lower part of the fetus out of the uterus before completing the abortion. We are not aware that the medical community regards this method of abortion as morally distinct (or medically different in a meaningful way) from other late-term methods. However, abortion foes have given the procedure a new, emotionally charged name of "partial birth abortions" in order to suggest otherwise. Pro-choice activists warn that the bill interferes with a doctor's choice of medical procedure, and they accuse right-to-life partisans of targeting this procedure in order to show disturbing pictures that will arouse general opposition to abortion.

Only three or four doctors in the United States perform this specialized procedure, and the total number of D & X abortions annually is probably under 500. By contrast, about 1.5 million abortions are performed each year in the U.S., of which about 13,000 are performed after 20 weeks. We do not know what proportion of D & X abortions occur between 20 weeks and viability (a point that usually arises following the 24th week), but D & X abortions seem to comprise a higher percentage of post-viability procedures. A more traditional method of performing late-term abortions is known as the D & E procedure, in which the fetus is dismembered within the uterus and then removed.

Although the D & X procedure can be used for purely elective abortions, it is also used in pregnancies that physically threaten a mother (e.g., severe diabetes) or when a severely deformed fetus is discovered late in the pregnancy. During a subcommittee hearing on the Canady bill, the most emotional testimony was given by a mother whose severely deformed fetus was detected late. She decided to have a D & X abortion because the trauma of watching a young child die a certain and painful death after birth was more excruciating.

Discussion

Mother's Health: The most significant constitutional objection to the Canady bill is that it permits D & X procedures only if the *life* of the mother is threatened. Extending the exception to include the *health* of the mother would be consistent with the bill that you signed in Arkansas and would probably be required by the Supreme Court, which recently affirmed that "*Roe* forbids a State from interfering with a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health." The Court indicated that such health threats would have to be "substantial," which seems to include threats to mental health but only of a serious nature. To the extent that barring D & X abortions would force women who needed abortions for health reasons to forgo what may be the safest abortion method, OLC believes the ban is constitutionally invalid.

Pre-Viability Abortions: Another potential constitutional problem is that the Canady bill bars D & X procedures even in the pre-viability period. The Court has held that states may not place an "undue burden" on pre-viability abortions, and this bars any regulation that "has the purpose or effect of placing a substantial obstacle in the [woman's] path." OLC expresses its "concern" that barring a particular method of safe abortion could constitute an "undue burden." It is difficult to predict whether a court would so hold -- both because the contours of the recently announced "undue burden" standard are not fully known and because the risks of using other methods of pre-viability abortions (instead of the D & X) are unclear. It would be consistent with your prior views, however, to remove pre-viability abortions from the scope of the bill. In 1990, for example, you stated: "While I ... supported restrictions on public funding and a parental notification requirement for minors, I think the government should impose no further restrictions. Until the fetus can live outside the mother's womb, I believe the decision on abortion should be the woman's not the government's."

Post-Viability Fetal Deformity: Severe fetal deformities are sometimes detected only after viability. Obviously, a pre-viability exception would do nothing to authorize D & X abortions in such cases. Even if a health exception were added to the Canady bill, it is doubtful whether doctors would rely on that exception to perform fetal deformity abortions since they would probably interpret a criminal statute conservatively, to avoid the risk of imprisonment. Rep. Schroeder tried but failed (in committee) to add a "health" exception to the Canady bill that expressly defined health to include "threats from severe fetal abnormality." This may have been intended to help doctors who perform fetal deformity abortions by underscoring that deformities *can* implicate maternal health. But the Schroeder language seems unlikely to help by much, since the doctor must still decide that a given fetal deformity threatens maternal health, and that decision remains subject to criminal challenge.

Recommendation

(1) We believe you should take a position on the Canady bill. Many members of the Judiciary Committee (including pro-choice members) have asked for a statement, and the bill in some form probably will pass the House and may well succeed in the Senate.

(2) We also believe you should oppose the bill by emphasizing the strongest constitutional objection: the bill's failure to contain a health exception. Probably, the statement should also refer to the bill's problematic application to pre-viability abortions. One way to combine both concepts would be to define the "health" exception so that it would permit D & X abortions not only when a pregnancy threatens maternal health but also when (in the pre-viability context) the doctor determines that the D & X procedure is *safest* for the mother. By framing the issue as one of maternal health and safety, you should be able to keep the debate at the proper level of principle -- especially the principle that medical judgments should be left to doctors. On the other hand, you will be relying on a factual predicate -- the medical superiority of the D & X method -- for which we have little evidence.

(3) In defending D & X abortions in the pre-viability period (when most such abortions are by other methods), you may be placed in the position of defending a particular *procedure* that is publicly controversial. If, however, you initially decide not to defend pre-viability D & X abortions, you may encounter greater difficulties later on. The bill may well be amended to protect the woman's health. You would then face the question whether to object to the pre-viability bar or, if you did not object, whether to sign a bill that might well be unconstitutional. It would be more difficult to raise the pre-viability objection at this later point if you have not even mentioned it in an initial statement.

(4) We think it is not advisable to address separately the issue of fetal deformity abortions. Adding a health exception to the Canady bill should permit *some* abortions where fetal deformities clearly jeopardize maternal health. While the bill's criminal penalties will doubtless have a chilling effect on doctors' medical judgments in such cases, that is unlikely to be alleviated by the Schroeder amendment (or other similar language). The chilling effect probably can only be eliminated by adding a further exception to the bill that would

expressly permit abortions for certain fetal deformities. Such a proposal would cloud the bill with a further controversy and, if adopted, could even authorize abortions in circumstances that you would find unacceptable.

Given all of these considerations, we recommend issuing a statement along the lines indicated in the second paragraph immediately above (option #3, below).

1. __ Take no position on the bill
2. __ Oppose bill solely because it lacks a health exception
3. __ Oppose bill because it lacks both a health exception *and* an exception for pre-viability abortions when the D & X method is the safest.
4. __ Let's discuss

file abortion

Federal employees are urged to switch health plans

Saying that President Bill Clinton "has won the battle but not the war" on taxpayer-funded abortions, Rep. Chris Smith (R-NJ) is urging federal employees to switch their health coverage to plans that do not cover abortion.

LETTER FROM THE HILL

Catholic News Service

For the first time since 1983, federal employees will be able to choose health plans that cover abortion on demand, because of a provision of the Treasury, Postal Service and General Government Appropriations bill for fiscal 1994. Clinton signed the bill into law in October.

In a letter to colleagues last week, Smith and Rep. Henry Hyde (R-IL) said their offices had received "calls from several federal employees who do not wish to participate in a health plan that covers elective abortions." They therefore provided a list of some of the participants in the Federal Employees Health Benefits program that do not cover elective abortions.

Federal employees can choose a new health plan during the "open season" enrollment period, but the enrollment period lasts only through Monday.

COMPANIES THAT ARE not covering abortions, except to save the life of the mother, include Government Employees Health Association, Aetna Mid-Atlantic, Health Plus, NAPUS, Rural Carrier, SSEHA (Secret Service) and Panama Canal Area, Smith said.

But, he said, dozens of federal employees' insurers — including Blue Cross/Blue Shield, BACE, Alliance and Kaiser Mid-Atlantic — "have turned their backs on their most vulnerable patients — unborn children. They've abandoned healing in favor of killing small children."

Smith noted that some plans which include abortions in the Washington area may exclude them in the plans offered to other areas.

The New Jersey congressman said the new policy on abortion will affect his own family's health coverage.

"MY FAMILY AND I have been enrolled in an HMO called Kaiser Mid-Atlantic for over a decade," he said. "To a large extent, we have been satisfied with the care we've received.

"Sadly, Kaiser too has turned from healing and nurturing to killing babies," Smith added. "My wife and I are now dropping Kaiser and we are switching to a pro-life health care provider."

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Uneven & Unequal

Insurance Coverage and Reproductive Health Services

The Alan Guttmacher Institute
New York and Washington

abortion file

Abortion talking points - Sunday, July 17, 1994

*** As the President said during an editorial board meeting on Friday, most plans cover abortion now. There are some interesting ideas floating around in the Congress and they are trying to work something out that satisfies all concerned.**

* The Administration stands by its plan and as Leon Panetta said today women should have the ability to choose. Under the President's plan, abortion, like other procedures, is covered when a doctor deems it medically necessary or appropriate. There is a conscience clause that would permit doctors and health care institutions to choose not to perform abortions for religious or moral reasons. As is true under most plans today, plans would cover abortion services, but women would have the ability to choose whether to use these services and doctors and hospitals would have the ability to choose not to perform these services.

Was Mr. Panetta signalling that the Administration is backing away from its position?

Again, as the President said, most plans cover it today, but this is an issue that will be debated in the House and the Senate. The Administration stands by its plan. We will work with members of Congress as they debate this contentious issue.

Will the President sign a bill that does not include abortion coverage?

The President has put pregnancy-related services in his plan and the Administration will fight for it. It's an issue that will be played out on the House and Senate floors.

ABORTION

As you know your remarks in response to a question about abortion at the League of Women Voters were misrepresented in media reports. It's possible that you will get a question based on those erroneous reports. The most difficult abortion question is when it is posed as restricting choice: we deny people who wish to join plans not covering abortion the option to do so. A suggested answer is below.

Question: Many people think abortion is morally wrong. Why should their tax dollars go to pay for covering abortion on demand?

Answer: One of the major goals of our reform is to guarantee people health benefits as good or better than they have today. Most private health care plans cover the full range of reproductive services today, and our plan will cover abortion when a doctor determines it is medically necessary or appropriate.

A conscience clause ensures that doctors and health institutions - such as religious hospitals - will not be required to provide any services against their moral or religious beliefs.

The President has always said he feels abortion should be safe, legal, and *rare*. That is why we are doing everything we can -- through health care reform, through welfare reform, and through other school-based prevention initiatives -- to dramatically reduce the number of unintended pregnancies.

Q: But shouldn't people be given the option to join plans that don't provide a service they have such personal and moral objection to?

Answer: We think comprehensive benefits should be spelled out in law, and for security, portability, and simplicity reasons, that every insurance plan should cover the same things. There will no doubt be plans that are organized by religious hospitals and are staffed by providers who would not themselves be required to perform services they thought were wrong. If a plan didn't provide a service directly, and someone in that plan had a medical need for that service, the plan would have to arrange for that service outside their plan.

Q: You indicated earlier this week that you would be willing to give up abortion coverage in order to get health care reform? Is that the case?

Actually what I said was quite the opposite -- I said that now is no time to compromise. I said we should be focusing all our efforts on fighting for universal coverage. Most women with private insurance have coverage for abortion services today, it is part of our comprehensive benefits package, and we will fight for comprehensive benefits.

AM Health Care-Abortion, 1st Ld-Writethru, a0631,630
Administration Official Suggests Compromise On Abortion
Eds: INSERTS 4 grafs, Democratic senators meet Clinton at White House, after 12th pvs, `a Time-CNN...'
By JIM ABRAMS= Associated Press Writer=

WASHINGTON (AP) The administration indicated support Sunday for a compromise that would give care providers an option on whether to provide abortion services under a national health care reform plan.

Incoming White House Chief of Staff Leon Panetta said the administration hopes to work with the House and the Senate to arrive at a compromise stressing the rights of people to a choice on the abortion issue.

The government, Panetta said on NBC's ``Meet the Press,'' shouldn't ``necessarily impose one approach or the other.''

The offering of abortion benefits has become a major sticking point in congressional debate over the final shape of health care reform bills.

Anti-abortion lawmakers have voiced strong opposition to using taxpayer money for abortion benefits, but some 70 members of the House said last week they will reject any plan that does not treat abortion the same as any other medically necessary procedure.

All four health bills that emerged from House and Senate committees contain abortion coverage, although one, approved by the Senate Finance Committee would let any employer or health plan refuse for religious or moral reasons to buy or provide abortion coverage.

It was that approach that Panetta appeared to be endorsing when he said that people should have a choice on abortion issues and ``if we provide any kind of major health care reform in this country, people ought to continue to have that choice.''

President Clinton in an interview with The Philadelphia Inquirer last week, said three-fourths of private insurers now cover abortion and it wouldn't be right to remove that benefit in a national plan. He said he hoped a compromise could be worked out and noted ``there are some interesting ideas floating around in the Congress.''

Senate Minority Leader Bob Dole, R-Kan., speaking on CBS' ``Face the Nation,'' said he would not favor the inclusion of abortion benefits in a health care package.

``If there's going to be a health care bill, we can't fight every battle. We're so divided now,'' he said. ``My view is it's going to be a quagmire. Nobody has the votes to pass anything right now.''

A Time-CNN poll of 600 people released Sunday found that only 41 percent favored federal payments for abortions, against 52 percent who were against the idea. That was a reversal from a May 1993 poll that found 50 percent favoring abortion benefits and 44 percent against.

Clinton exchanged ideas on health reform strategy with a small group of Democratic senators in the Oval Office on Sunday.

One of them, Sen. Dennis DeConcini, D-Ariz., said that in the end, the fate of the reform effort ``depends on the Republicans, whether they want to kill this or fund a compromise.''

Another, Sen. Howell Heflin, D-Ala., said compromise remains possible.

``Everyone says there's going to be a bill passed,'' Heflin said. ``What's in it hasn't been written yet. We're looking at everything, trying to come up with something that accommodates the purposes'' of health insurance reform.

Rep. Kweisi Mfume of Maryland, a liberal Democrat and head of the Congressional Black Caucus, said the president faces a ``difficult balancing act'' in satisfying all those with interests in specific health care issues.

He said on NBC that ``as long as the president does not abandon his major commitment to have a comprehensive health care reform package, then the party ought to at least be with their president.''

**** filed by:APE-(--) on 07/17/94 at 15:49EDT ****

The Philadelphia Inquirer 1/16

Clinton defends health-care plan, seeks a compromise on abortion

A1

In Philadelphia, the President tried to stem a clash with Catholic bishops over the hot issue.

By Vanessa Williams
and Roger Smith
INQUIRER STAFF WRITER

President Clinton yesterday defended his proposed health-care plan, including abortion services, but stopped short of declaring war on the nation's Catholic bishops who have vowed to work to defeat any national insurance plan that covers abortion.

Instead, the President said, he was confident that Congress could work out a compromise that would be acceptable to all parties in the volatile debate that has threatened to kill what is currently Clinton's most important domestic initiative.

Clinton said his dilemma was that three-quarters of the nation's private insurance companies covered abortion, and his proposal called for folding the uninsured into the current system.

"I didn't feel that . . . we should go in and change three-fourths of the health-insurance policies in the country. That wouldn't be right, either," he said on a trip to Philadelphia.

"It's a difficult issue because of how we're trying to do this, but there are some interesting ideas floating

See **CLINTON** on A7

Democratic lawmakers accuse the fast-food giants of hypocrisy in the health-care debate. **A2.**

A7

The Philadelphia Inquirer / WILLIAM F. STEINMETZ

At Philadelphia International Airport yesterday, the President was welcomed by Dawn Yost (left) and Jan Gottenberg, who wrote to the White House to support Clinton's health-care proposal. Mayor Rendell stands behind them.

The Philadelphia Inquirer 7/16

A7

Clinton visits city, defends health plan

CLINTON from A1

around in the Congress, and my latest information is that they think it can be worked out," Clinton said. "The bishops may not like exactly what comes out, but they may feel more comfortable about it."

Clinton's comments came during an hour-long session with The Inquirer editorial board at the Public Ledger Building near Independence Hall, during which the President focused mainly on national health care and foreign policy.

The President was in Philadelphia to act as host for a fund-raising event for Pennsylvania Democratic candidates Harris Wofford, who is running for re-election to the U.S. Senate; Lt. Gov. Mark S. Singel, who is running for governor, and Thomas Foley, who is running for lieutenant governor. Clinton also pushed his plan at a town-square rally in Western Pennsylvania, where the warm reception he received was exceeded only by the 90-plus-degree temperatures.

Clinton's defense of his health-care proposal was his first public response to an announcement earlier this week by the bishops of the 60-million-member Catholic Church that they intended to fight to the death any health-care plan that included abortion as part of its benefits. Several members of the House immediately retorted that they would defeat any plan that removed abortion. This month, the Senate Finance Committee voted to further restrict abortion coverage in the proposed health-care bill.

The President's proposed bill includes a "conscience clause" that would exempt doctors and medical facilities who object to abortion from having to perform the service. But all health-insurance plans would have to guarantee access to abortion.

"We tried to bend over backwards to have all the conscience exemptions we could and to still preserve the rights of the people that the Supreme Court has articulated and [that are] in their own insurance policies," Clinton said.

Abortion opponents are not the only potential sources of trouble for the President's plan. Medical groups, businesses and some taxpayers are wary of the plan, fearing it would drive up costs and limit benefits.

"The forces of change are more diffuse and not as well-organized and, therefore, not as able to manifest intense pressure as forces against change," Clinton said. But he insisted that his plan had support. He talked about the enthusiastic response he received from 10,000 people in Greensburg, Pa., who cheered his call for universal coverage.

Still, there were naysayers in the crowd gathered in the Westmoreland Courthouse square. At one point, Clinton broke from his script to challenge signs that called his plan "socialism" and "rationing."

Clinton shot back that health care of 600,000 Pennsylvanians "has been rationed."

"They are not on welfare, they are working, and they do not have it," he said. "They're not poor, they're not rich, they're not politicians, and they're not in jail, so they can lose their health insurance."

Upon arriving at Philadelphia International Airport, Clinton was greeted by two area women who had written to the White House, encouraging the President to push forward on a health-care plan.

Dawn Yost and Jan Gottenberg were thrilled and encouraged by their brief meeting with the President.

"He said he was very moved by my letter," said Yost, a 44-year-old elevator operator from Blandon, Pa.

Yost had written a letter, discussing the difficulties she has had since being diagnosed with breast cancer in the summer of 1992. During the last two years, she was forced to change insurance companies and fired from her job with a Blandon snack-food company.

Gottenberg, a first-grade teacher in North Philadelphia, said she was so nervous that she "couldn't remember much of anything [Clinton] said."

Clinton signed Gottenberg's copy of *The President's Health Security Plan*, the White House book on American health care.

Her letter to Clinton, which is reprinted on page 71 of the book, discussed the problems of unnecessary emergency-room use and the lack of preventive care in low-income communities.

Both women left the brief encounter impressed. "He seems like a very nice man, very down to earth," Yost said. "I believe he really is trying hard."

file abortion

Excerpt of Interview: First Lady Hillary Rodham Clinton with WJAR Radio, 10/24/94

Q. One of the biggest buzz words in America today is "abortion." And in the article, [Woodward] suggests that you feel that abortion is wrong, but should not be criminalized, is that accurate?

That is. Obviously, in some cases, it is a very difficult decision, and I respect the right of conscience. You know I've come in my own mind to think about this issue as really pro-conscience in the sense of trying to change people's attitudes and feelings so that if a decision is made to choose abortion it is done only after the most careful soul searching. I think the issue has become so polarizing and neither side on the divide is really reflecting what most of us in the great muddled middle feel, which is that we do not approve, we are not happy about the number of abortions but cannot imagine what criminalization would do to women and doctors and just the fabric of our life together ... I would like it if we could perhaps call a verbal truce and for people on all sides to work together to figure out how we make abortion, in my husband's words, safe and rare, but legal.

Interview w/WJAR Radio 10/24/94:

Q: Mrs. Clinton how are you?

I'm fine how are you doing?

Q: We understand that you had dinner, or at least met with Princess Diana this weekend, will you tell us about that?

Yes, I did, I had lunch with her on Saturday. At the British Embassy. About 30 people were invited to come there, and I had some private time with her before the lunch, and found her to be a delightful, down to earth, funny, charming young woman, I must say that I was very pleased to have had the opportunity to see her face to face. Because as someone who often reads about myself in the paper, I never believe anything anymore unless I absolutely get to meet someone.

Q: Mrs. Clinton did you point out to her that if she was really trying to get away from the harsh glare of the media, that New York was the wrong place to go?

Well New York and Washington, you're absolutely right. But I think she is interested in the arts, she's interested in projects like AIDS treatment and prevention, particularly for children. In addition to meeting people and attending some social engagements, she really pursued some of those interests, which I respect a great deal about her.

Q: We talked earlier this hour to Kenneth Woodward of Newsweek, who as you know does a story on you in the, on your religious beliefs, in the magazine, this week, and it is somewhat surprising because I don't think most of us ever thought of Hillary Clinton as a "Old Fashioned Methodist," is that an apt description?

Well I, think it is. I mean I have very strong religious beliefs, and take my faith very seriously and personally, I don't talk about it much. I was willing to talk to him because he is a serious journalist who has studied written about religious beliefs for years. But it is something that has been a big part of my life, ever since I was a little girl.

Q: One of the biggest buzz word in America today is "abortion." And in the article, he suggests that you feel that abortion is wrong, but should not be criminalized, is that accurate?

That is. Obviously, in some cases, it is a very difficult decision, and I respect the right of conscience. You know I've come in my own mind to think about this issue as really pro-conscience in the sense of trying to change people's attitudes and feelings so that if a decision is made to choose abortion it

is done only after the most careful soul searching I think the issue has become so polarizing and neither side on the divide, is really reflecting what most of us in the great muddled middle feel which is that we do not approve, we are not happy about the number of abortions but can not imagine what criminalization would do to women and doctors and just the fabric of our life together.

Q: Will prochoice then to you does not necessarily mean abortion on demand?

No it does not. The debate has really gotten so distorted over the last years. I would like it if we could perhaps ~~to~~ call a verbal truce and for people on all sides to work together to figure out how we make abortion in my husband's word, safe and rare but legal. There are situations that I do not think that any of us should substitute our own judgement or experience or morality for that of a woman and her physician, or in many instances even her parents or her husband. But I think that we have to do a better job of talking about what is really a difficult moral dilemma. As opposed to screaming at each other across the divide that I think is very unproductive.

Q: That is a far more reasoned explanation of a point of view that I have ever heard from either side of the very zealous left and right.

Well, you know I think that is one of our problems in America right now. Many of us who are working our way through difficult decisions, we need to cool our rhetoric and we need to stop the verbal barrage and try to work through how we are going to deal with very serious problems, that is one. But certainly the high divorce rate bothers me, the break down of the family, teenage pregnancy, and the violence in our communities. I know it's hard to say in a political season but I would be a lot happier instead of hurdling thirty second ads at each other, candidates would be given the opportunity by the electorate to have much more thoughtful discussions with each other and with the voters. I regret deeply that we are turning this election into sloganeering, especially when I think that there has been some honest effort on the part of my husband and Democrats as well as some Republicans in the last twenty months deal with some very tough issues. And that is what we should look at.

Q: Both sides are great at mudslinging on television and we live in a world of soundbites and at least for now that's the way it is.

It is regrettable though.

Q:Despite the fact that nobody likes it. Speaking of politics it is going to be a political visit for you today, you are going I assume campaigning and raising some money for Bob Carr and some other Democratic candidates.

That right I am and I am looking forward to being there to.

Q: Where will you be?

I will be in Detroit and right outside of Detroit. I am going first to Connecticut and then I fly into the airport. I will be with Mrs. Carr and we are going to a fundraising event, actually I guess two or three of them in a row. I will be seeing a lot of people who are supporting Bob Carr for the Senate.

Q: On the last poll that I heard about he is probably five to eight points behind Spencer Abraham, his Republican opponent. He has a long way to go. This is a very interesting as you know off year election year, all kinds of interesting election races around the country, a couple of them here but it looks it is possible that the United States Senate could be controlled by the Republicans. How does your husband, the President, obviously he does not like this, but what does he say about it?

I think that he would say as he has over and over again that we hope that voters are making informed decisions and not just reacting as it is often the case with any election but particularly today, the midterm election. I was laughing with my husband the other day because if you look at somebody like Bob Carr I mean it seems to me that the people of Michigan wanted an economic recovery that would be fueled by responsible budgeting in Washington and he voted for that. The deficit as of today is going to be 203 billion, and that is far below what it was projected to be when George Bush was President and my husband was elected. I think that it is so ironic that for some reason neither this President nor courageous members of Congress, like Bob Carr gets the credit they deserve for voting for a crime bill which is going to put I think some three to four hundred more police on the streets in Michigan, which will have an impact on crime.

Q: But as you know the crime bill was a very criticized bill, the word pork was associated with it as much as crime was. It was not a universally popular bill.

But isn't that interesting. Here was a bill that had been stuck in Washington and all of the gridlock over the last six years. This President breaks it loose, the Republicans voted for everything that was in that bill. Then at the end they adopt a very callous political strategy to call things that they had voted for pork in order to try to deprive the President of a victory, that was really a victory for the people of this country. So my problem is that I do not mind anyone being against anything my husband, Bob Carr, or any Democrat is for but I want them to have accurate information. If they have accurate information, they are going to scratch their heads and say you know these fellows really have done a lot on the deficit and crime and a lot of other issues. It is just unfortunate that too

often the technique that calling something by a name is more effective then getting the facts out.

Q: But it has been the rule hasn't it in politics in America for as long as politics has existed in America.

Well, it's been and has always been apart of our political life but it seems to be worse today. I think that maybe because people are preoccupied with their own lives, there are a lot of issues that all of us are trying to address, our families and our work, our communities, and because of the relentless barrage of advertising and a lot of the other means of repetitively saying something whether it is true or not. I think that people get a little off balance. Again I want everyone to have accurate information. For example, the idea that there is something like 400,000 people in Michigan who are actually getting a tax break because of the budget. There is a vast majority of people in Michigan who saw no difference at all in their taxes where 41,000 or so of the wealthiest people in Michigan had to pay their fair share because frankly they did not during the 1980's. Now as a person who was raised in the middle class by a conservative father, I've listened to my father who is no longer with us, speak in my head and I think that he would say that is a pretty good deal. But for some reason that is not getting through to people and I think it is because of all the other issues in our lives right now.

Q: Would you campaign for Ted Kennedy in Massachusetts, where he is apparently has the fight of his life on his hands.

I already have and I would be happy to do so again. I have seen first hand what an effective Senator he is and not only in terms of important legislation, like all of the school legislation we have passed in the last twenty months, particularly college loans for middle income families, but because he is one of the Senators who can effectively work with Republicans and Democrats, which may be a surprise to some of your listeners. For instance, Senator Orinhatch from Utah, a very staunch Republican, had said over and over again that Ted Kennedy is one of those Senators who can cross party lines. And my goodness we need him now more than ever.

Q: Mrs. Clinton it has been a pleasure to talking to you this morning and I hope that you will enjoy your visit to Detroit this afternoon. We will try to hold off those forecasted late afternoon showers.

Oh, thank you and it was a pleasure talking to you again.

Q: The nation's First Lady Hillary Rodham Clinton on her way to Detroit and it is ten minutes before nine.

Talking Points on Abortion

The President has always said that he feels abortion should be safe, legal and rare. That is why we are doing everything we can -- through health reform, through welfare reform, and through school-based prevention initiatives -- to reduce the number of unintended pregnancies.

Most private health insurance plans cover the full range of reproductive services. Our goal is to preserve the benefits that people with insurance already have and to extend health security to all Americans by guaranteeing private health insurance that can never be taken away.

None of the bills currently being considered by Congress would lead to the dramatic increase in abortions that some have imagined. None of the bills would overturn state laws regulating abortion that, for example, require parental notification or waiting periods. In addition, none of the bills would require any state or health plan to build or maintain abortion clinics or providers. The Administration will support any amendment to clarify this.

Abortion

file in health care
section of files
Under
ABORTION

PHOTOCOPY
PRESERVATION

Approaches

- States option amendment re rape + incest
- block rec – "health of mother"

Fell Obey - what do we want in his mind?
- rape, incest + some def'n of "health"

7/13/94

Choices About Coverage for Abortion Services

- The cost of abortion coverage is $8.67 per policy, based on the estimated community rate required to fund abortions.

- An individual may waive abortion coverage if the individual has a moral or religious objection to this service. If the individual waives abortion coverage, the individual's premium obligation is reduced by the appropriate share of the community-rated amount attributable to abortion coverage.

- A religious employer may choose not to pay for abortion coverage. If the employer chooses not to pay for abortion coverage, the employer's premium contribution is reduced by the employer share of the community-rated amount attributable to abortion coverage. An employee may elect not to pay the difference.

  A religious employer is an employer that: (1) qualifies for tax exemption (under 501(c)(3) or ERISA "church plan" definitions); and (2) is, in whole or in substantial part, owned, supported, controlled, or managed by a particular religion or by a particular religion or by a particular religious corporation, association or society.

- Subsidies are reduced by the appropriate share of the community-rated amount attributable to abortion coverage. Individuals who do not waive abortion coverage must pay the difference.

- All policies include coverage for abortions that are necessary to save the woman's life or as a result of rape or incest.

- A religious plan sponsor may decline to include abortion services other than abortions that are necessary to save a woman's life or as a result of rape or incest. A religious plan sponsor is a sponsor that meets the definition above.

Congress of the United States

House of Representatives

Washington, DC 20515

August 12, 1994

A SMOKE SCREEN -- NOT A COMPROMISE

Dear Colleague:

There were a flurry of news reports yesterday on an alleged compromise with regard to abortion in health care reform legislation. These accounts related that "lawmakers who support abortion rights...said they have crafted a compromise." Our colleague, Mrs. Schroeder, commented, "I think it's a wonderful compromise."

Forgive me if I'm a little skeptical, but this supposed "compromise" is being promoted by Members who are among the strongest supporters of publicly funded abortion on demand and the strongest opponents of any state restrictions on abortion: Members who are cosponsors of the "Freedom of Choice Act," which would wipe out all state parental consent; informed consent, waiting periods and other reasonable laws, including laws limiting third trimester abortions; Members who voted to repeal the Hyde Amendment. Yet these same Members are now coming forward to say that they are willing to *codify* the Hyde Amendment. This makes me very skeptical.

From the information I have been able to glean about this so-called "compromise," I believe it is a sham. It is not the status quo and it is not a substantive concession.

- **Under the Clinton-Gephardt bill, the new Medicare Part C trust fund would pay for abortions for any reason, at any time. The "compromise" proposal also would allow all low-income women who want publicly subsidized abortions to get them. This is *not* the status quo.**

Currently the Hyde Amendment, together with the laws and policies of 36 states, prevent taxpayer funds from paying for most abortions. Under the so-called compromise, federal and state tax dollars would go into Medicare Part C and other subsidy programs, which will pay for abortions without limitation. The so-called separation of funds is a mere bookkeeping trick.

- **The "compromise" proposal would still force employers to contribute to plans (including Medicare Part C) which pay for abortion on demand. This is not the status quo.**

It is absurd to say that federal tax dollars would not pay for abortions, when the bill would force employers throughout the United States to contribute to Medicare Part C, which will pay for abortions on demand for the over 40% of the population receiving subsidized health care. These federally mandated premium payments to Medicare Part C or any other government-managed health care insurance *are* federal taxes on employers.

- **The Clinton-Gephardt bill, with the alleged "compromise," turns on its head current policy with respect to private insurance coverage for abortion.**

Under existing insurance policies, individuals and employers may select plans that cover abortion, but it is not a federally defined "guaranteed benefit." This phony compromise would enshrine abortion as a basic "benefit." This is not the status quo.

Poll after poll indicates that a clear majority of Americans do not want abortion to be included in a basic benefits plan. (In a July 14-17, 1994 *CBS News/New York Times* poll, only 16% of surveyed Americans favored the inclusion of abortion in the basic plan.) To maintain the status quo and yield to the wishes of most Americans, the bill should *exclude* abortion from the basic benefits package, but permit individuals to buy abortion insurance, if they want it, with their own money. That is what the Hall-Hyde-Kaptur Amendment would do.

- **The Clinton-Gephardt bill, with this phony "compromise," would still require (and help fund) the creation of hundreds of new abortion clinics throughout the states to assure ready access to *all* the services in the guaranteed benefit package, including abortion.**

- **Press accounts say that the "compromise" would "leave in place all existing state abortion restrictions"**

Even if this were a genuine protection, does it only apply to "existing" laws and regulations? Would states be able to enact new constitutionally permissible limitations on abortion?

Don't be fooled. There is only one amendment to the Clinton-Gephardt bill that will keep abortion policy as close as possible to the status quo.

VOTE FOR THE HALL-HYDE-KAPTUR AMENDMENT.

Sincerely,

HENRY J. HYDE
Member of Congress

For further information or documentation, contact:
National Right to Life Committee, (202) 626-8800, ext. 120, or (301) 502-1170

BC-HEALTH ABORTION

MRS CLINTON WON'T PREDICT ABORTION COMPROMISE

WASHINGTON (Reuter) - First Lady Hillary Clinton said Tuesday it was too soon to predict whether there would have to be a compromise on abortion in order for health reform to pass Congress.

She said the first priority is to work out how to finance universal coverage, or ``else everything else we want to do becomes moot.

President Clinton's health reform proposal includes comprehensive reproductive health services among the basic benefits.

Whether abortion remains part of that package is certain to be one of the most controversial aspect of the health care debate in Congress this summer, with people on both sides threatening to vote against the bill if it contains abortion provisions they find unacceptable.

Some lawmakers want a compromise that would give insurance plans the option of whether or not to cover abortion. Most private insurance plans currently do cover pregnancy termination.

Asked after giving a speech to the League of Women Voters on health care her views on an abortion compromise, Clinton said, ''I think that that's one of those questions that we just cannot even answer right now, because we have to get to the forest of universal coverage first.''

Mrs Clinton named several services,including reproductive services, mental health and preventive medicine, that she would like to see covered in the basic benefits, but said it was too soon to what the final package would contain.

``The way this whole debate is developing, it is very difficult to tell exactly where we are going to have to make whatever compromise or where it's going to be taken out of our hands and the Congress will basically argue it out, as will happen on a number of these issues. So I don't think anybody is ready to talk about compromise on any aspect.''

REUTER

**** filed by:RB--(--) on 06/14/94 at 15:27EDT ****
**** printed by:WHPR(JEL) on 06/15/94 at 09:22EDT ****

PM Hillary Clinton-Health, 1st Ld-Writethru, a0552,450
Mrs. Clinton Won't Rule Out Abortion Compromise
With PM Health Reform
EDs: SUBS 8th graf, She criticized..., with 3 grafs to UPDATE with reaction from Lowey; picks up 9th pvs, Moderates in...
By CHRISTOPHER CONNELL= Associated Press Writer=

WASHINGTON (AP) Hillary Rodham Clinton today refused to rule out the possibility of sacrificing abortion coverage in order to win guaranteed health care for all Americans.

She told the League of Women Voters it was hard to tell ``exactly where we are going to have to make whatever compromise, or where it's going to be taken out of our hands and the Congress will basically argue it out.''

The league is a strong supporter of both universal health coverage and reproductive health care, including abortion, for women.

Asked point blank if they should ever consider backing down on abortion rights to achieve comprehensive health reform, the first lady replied, ``That's one of those questions that we just cannot even answer right now because we have to get to the forest of universal coverage first.''

She said the White House wants guaranteed health benefits for all Americans, including coverage for reproductive health services as well as mental health and prevention.

``I don't think anybody is ready to talk about compromise on any aspect,'' Mrs. Clinton said.

``Let's focus on getting everything possible done to make sure we get a system for universal coverage, and then I think we can really begin to fight out some of the issues that will come from that,'' she said.

Rep. Nita M. Lowey, D-N.Y., co-chair of a task force of pro-choice House members, said later that Mrs. Clinton ``could have been stronger on the issue.''

``As far as we're concerned, basic women's health care ... including abortion, cannot be negotiated away,'' she said. ``For those who'll say there'll be a fight if you put it in, I'm saying there'll be a fight if you take it out.''

Mrs. Clinton criticized those pushing voluntary methods of expanding health insurance without government coercion. That approach ``is guaranteed to fail,'' she said.

Moderates in both parties are pushing bills that would try to make insurance more affordable and available without mandates.

``Just as with Social Security, we cannot wait very much longer for some miracle to occur that will enable everyone to have guaranteed insurance without any intervention in terms of legislation,'' Mrs. Clinton said.

She praised the 200,000-member league for supporting coverage for all and cost controls, and took a slap at unnamed groups that have backed off the idea of making all employers help pay their workers' premiums.

Among the groups that have retreated from strong support for an employer mandate are the American Medical Association and the U.S. Chamber of Commerce.

**** filed by:APE-(--) on 06/14/94 at 13:34EDT ****
**** printed by:WHPR(JEL) on 06/15/94 at 09:22EDT ****

PM-Health Reform, 3rd Ld-Writethru, a0549,850
No Consesus on Health Reform in Senate Finance Committee
EDS: INSERTS 4 grafs after 4th pvs, Committee Chairman, to add Mrs. Clinton comments on abortion coverage and action in House committee; SUBS 5th graf pvs, Such disagreements, for transition and picks up 6th graf pvs, Packwood put
By NANCY BENAC= Associated Press Writer=

WASHINGTON (AP) Senate leaders emerged from a meeting with President Clinton today saying ``there is not now a majority for any health-care reform plan'' in a key committee, but they agreed to continue their work.

Recognizing the lack of consensus, ``the president asked that we take no votes in the committee at the moment,'' said Sen. Robert Packwood of Oregon, ranking Republican on the Senate Finance Committee.

``He obviously doesn't want any vote that causes his plan to be defeated,'' Packwood said.

Committee Chairman Daniel Patrick Moynihan, D-N.Y., summed up the meeting: ``We agreed that ... there is not now a majority for any health-care reform plan in the Senate Finance Committee, that we will continue to work on a bipartisan basis to provide legislation that covers everybody.''

Meanwhile, Hillary Rodham Clinton refused to rule out the possibility of sacrificing abortion coverage to win a universal plan.

She told the League of Women Voters that ``the way this whole debate is developing it is very difficult to tell exactly where'' compromises will be made.

``Let's focus on getting everything possibly done to make sure we get a system for universal coverage and then I think we can really begin to fight out some of the issues that will come from that,'' she said.

On another front, Democrats on the House Education and Labor Committee rejected, 28-15, a Republican plan that would require employers to offer, but not pay for insurance coverage for their workers.

Moynihan insisted Clinton's health-care reform plan was not dead, saying, ``Not at all. This a large piece of legislation and some of the principles are absolutely essential. Others are negotiable and he knows that.''

Packwood put it another way.

``At the moment, all plans are dead,'' he said. ``Anybody's plan.''

``There's not a majority for any single plan,'' Packwood added. ``So the question is, can we accommodate ourselves to different parts of different plans and reach a majority.''

The crux of the problem lies in Clinton's desire to guarantee coverage to all Americans, with employers forced to provide insurance to their workers.

``We are all wanting to go in the same direction but there is a strong, large feeling on the Republican side against compulsion that absolutely forces people to do things they don't want to do,'' Packwood said. ``That is sort of where we are.''

Moynihan said the legislators would return to Capitol Hill to try ``to put together combinations'' of various existing proposals.

``There are many forms of triggers (for universal coverage) that will be considered,'' Moynihan said. ``The president was open to any suggestions we had. He didn't make any commitments.''

Asked if Clinton can achieve universal coverage for all Americans without forcing employers to buy insurance for their workers, Moynihan said, ``We don't know yet.''

Moynihan gave a series of clipped answers on what happens next.

His time frame? ``Now.''

Will there be a plan this year? ``We better.''

Can the committee pass legislation by the July Fourth recess? ``I hope.''

Packwood said he raised the idea of enacting some health reforms now, without immediately including a requirement to provide coverage for all Americans.

Under this idea, ``we won't have a mandate today, but in three years the

president shall submit something and the Congress will have to vote on it. That was kind of agreeable to a lot of people,'' Packwood explained.

Under this type of a ``fast-track plan,'' the plan would either take effect automatically unless rejected by Congress, or Congress would have to take an up-or-down vote on the idea.

Packwood said he sensed ``some interest on the concept'' from Clinton.

Ed Lopez, an aide on the Finance Committee, said Moynihan ``wants to take a look at it.'' He added that other Democrats on the committee were interested in exploring that sort of idea as well.

Meanwhile, three top Clinton administration officials say the White House would not be upset if Congress decides to delay universal health coverage until after 1998.

``The idea of a phase-in is not new to us,'' Vice President Al Gore told reporters Monday. ``We proposed it.''

Treasury Secretary Lloyd Bentsen, in a separate interview with news services, praised a compromise suggested by Sen. John Breaux, D-La., that would impose no health-insurance requirement on small businesses before 2001.

``I don't want to sit here and endorse the plan in its entirety by any means,'' said Bentsen. ``But I think phasing it in certainly has some appeal. I think the administration could live with that.''

Ira Magaziner, the president's senior domestic policy adviser and an architect of the Clinton health plan, said ``there is no magic date'' for universal coverage and a phase-in would be ``a positive thing.''

The original Clinton plan set Jan. 1, 1998, as the date for universal coverage.

**** filed by:APW-(OR) on 06/14/94 at 11:51EDT ****
**** printed by:WHPR(JEL) on 06/15/94 at 09:22EDT ****

bc-abort
GRIDLOCK ON HEALTH
MAY HIT ABORTION
Eds: Sidebar to HEALTHCARE
By JUDI HASSON=
USA TODAY=
WASHINGTON Hillary Rodham Clinton isn't ruling out dropping abortion coverage to get health reform passed by Congress.

The possible compromise is a sign President Clinton health plan lacks Congressional support needed and that the administration is willing to deal on items previously off-limits.

Asked if the White House would back down on covering abortion, the first lady told the League of Women Voters Tuesday that it's too soon to say ``exactly where we are going to have to make whatever compromise.''

``There will be a fight if abortion is taken out,'' said Rep. Nita Lowey, D-N.Y.

Meanwhile, the health insurance industry is bringing back ``Harry and Louise,'' a yuppie couple featured in a $10 million ad campaign that helped turn public opinion against the Clinton plan.

Off the air since February, two new ads Monday will criticize new proposals.

The Health Insurance Industry Association had agreed to pull the ads after striking a deal with former House Ways and Means Committee Chairman Dan Rostenkowski on parts of insurance reform. The deal evaporated when Rostenkowski was indicted and gave up the gavel.

**** filed by:GN-F(--) on 06/14/94 at 21:45EDT ****
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Bishops Enter Health Battle With a Warning on Abortion

A1

By PETER STEINFELS

The nation's Roman Catholic bishops have warned the leaders of Congress that they are mobilizing millions of members of their church against any health care plan that requires all health insurers to cover abortion as part of a standard package of benefits.

In a letter to Congressional leaders this week, the bishops re-affirmed their support for changing the health system to achieve universal coverage. But they promised "vigorous opposition" to any health plan that includes a requirement of abortion coverage.

Although the bishops have stated this position repeatedly over the past two years, they have watched with consternation as each of the five draft health bills that have passed Congressional committees has included a requirement for abortion coverage.

"We haven't been listened to," said Helen Alvare, a spokeswoman for the the National Conference of Catholic Bishops. "It was our hope that by now we would have been able to impress on members of Congress the dramatic violation of our conscience that inclusion of abortion would be."

Currently, most private health plans include coverage of abortions, but Catholics and others have the choice of buying insurance that does not include it.

Requiring such coverage in a uniform national benefits package "will force millions of employers, churches and individuals to subsidize abortion in violation of their consciences," the bishops' letter said, and "will jeopardize the future of Catholic and other religious providers of health care."

The letter, sent to 30 leaders of Congress, was signed by Archbishop William H. Keeler of Baltimore, who is President of the bishops conference; Roger Cardinal Mahony of Los Angeles, chairman of the conference Pro-Life Committee, and Bishop John R. Ricard of Baltimore and the Domestic Policy Committee.

Church officials around the country are now beginning a stepped-up effort to press their opposition home in personal visits to political leaders and to mobilize Catholics in parishes, church organizations and throughout the extensive Catholic hospital system, in hopes they will make their views known to Congress.

Church officials said they hoped that when Congressional leaders and the White House craft final health legislation in the coming weeks, it will be apparent that the political costs of including abortion services will outweigh the benefits.

In effect, the Catholic leaders are offering a carrot and a stick. They have pledged their strong support for a major overhaul of health care that includes universal coverage, so long as it excludes abortion services. But they have also made it clear that a plan that includes abortion coverage will face organized opposition from Catholic leaders and groups around the country.

Continued on Page A15, Column 1

Health Care Caravans

Supporters of the Clinton health care proposal unveiled plans for bus caravans to Capitol Hill when Congress debates the issue. Page A15.

The abortion issue is one of the biggest concerns of the Democratic strategists trying to piece together a majority for a health care bill. Their fear is that coming down on either side of the issue will cost votes. With Democratic leaders increasingly aware of how narrow a margin they may be working with to pass a health care bill, the hunt will be intense for some kind of compromise.

Last month Hillary Rodham Clinton seemed to open the door to a strategic retreat, even on abortion, saying: "It is very difficult to tell exactly where we are going to have to make whatever compromise."

Abortion rights advocates, who note that most Americans already have abortion services covered in private insurance plans, have vowed to fight any effort to remove abortion from any new, standard benefits package.

"While everyone respects the dictates of individual conscience, we strongly oppose the bishops' plan to impose their views on women's reproductive health on society as a whole," said James Wagoner, executive vice president of the National Abortion and Reproductive Rights Action League.

The bishops will announce their intensified campaign at a news conference scheduled to be held today in Washington. They will also distribute the results of a national poll they comissioned that they say buttresses their political strategy. The survey, they say, shows widespread support for universal health-care coverage but also that this support plummets when abortion services are included among the required benefits.

The two-pronged position — support for universal coverage as well as strong opposition to including abortion services — distinguishes the bishops' position from that of some conservative Christian groups who not only oppose abortion but also oppose virtually any major health-care changes.

It is also central to the bishops' hope for mobilizing of Catholics well beyond the usual circles of fervent abortion opponents, such as Catholic doctors and nurses and church members working with low-income and minority populations.

In the health proposals before Congress, public funds would subsidize the insurance of poor people, and thus abortion coverage for them. But the Catholic leaders are objecting more broadly to the proposed requirement that all the country's insurance plans include abortion coverage.

This, they say, would go a drastic step beyond the current situation in which individuals and employers — including Catholic dioceses and agencies — can choose to buy plans excluding abortion services.

The proposals all include a "provider conscience clause" that would allow objecting hospitals and doctors to refuse to perform abortions.

But including abortion in a standard benefits package would still violate Catholic moral principles and the "First Amendment right of religious freedom," the bishops said in a letter to members of Congress dated June 13. If all insurance plans are required to cover abortions, then Catholics who pay into such plans would be subsidizing abortion even if they do not use this benefit themselves, the bishops assert.

In addition, the bishops said, if the networks of insurers, doctors and hospitals that are springing up around the country are required to offer abortion services then Catholic-run hospitals and clinics could be "effectively barred from leading such provider networks," since they could not in concience even refer patients for abortions elsewhere. These Catholic institutions "would increasingly be marginalized and relegated to the periphery of our health care system," the bishops said.

The solution, the bishops assert, is to exclude abortion from any standard benefits package and allow individuals who desire abortion coverage to buy supplemental policies. Yet from the point of view of abortion-rights supporters, this would be a step back from the current situation, where most people are covered routinely.

Some bishops and dioceses around the country have already begun the campaign on health care, and expect to intensify their lobbying in the months ahead.

"We have Catholic Charities, the pro-life office, the social justice groups and the health-care providers all working together," said the Rev. Michael D. Place, a consultant to Joseph Cardinal Bernardin of Chicago. "Each group has its own constituency, its own legislative liasons and grass-roots networks, and all of them are being mobilized for a common purpose," he said.

On May 26, Cardinal Bernardin delivered a speech on health care at the National Press Club in Washington, then met with Senator Carol Moseley-Braun, Democrat of Illinois, and with the House minority leader, Robert H. Michel, Republican of Illinois.

Other Illinois church officials have met with five other representatives from the state "and we are working through the rest," Father Place said. "In the years I've been in this work, I've never seen as well orgnized and concerted an effort for the bishops to interact with legislators.

"We are using all of our networks to get across the same message: a consistent ethic of life requires universal coverage and the exclusion of abortion," he said.

Bishop William S. Skylstad of Spokane, a generally liberal bishop who calls the inclusion of abortion "a very significant conscience issue" for Catholics, has written to pastors asking them to encourage parishioners to write their Senators and Representatives. "I lunched with Congressman Foley last week," the bishop said, "sharing with him our concerns."

> *"It was our hope that by now we would have been able to impress on members of Congress the dramatic violation of our conscience that inclusion of abortion would be."*
>
> **HELEN ALVARE**

THE NEW YORK TIMES, WEDNESDAY, JU

AKING INITIATIVE, NOMINEE DEFENDS CONDUCT AS JUDGE

ALLEGATIONS OF CONFLICT

Breyer Says His Investment in Lloyd's of London Did Not Violate Standards

A1

By NEIL A. LEWIS
Special to The New York Times

WASHINGTON, July 12 — Judge Stephen G. Breyer, President Clinton's Supreme Court nominee, moved swiftly today to defend himself against charges that he might have acted improperly by ruling on pollution cases while he was an investor in an insurance syndicate facing heavy losses from pollution lawsuits.

In his first day of testimony before the Senate Judiciary Committee, which is considering his nomination, Judge Breyer said he was confident that his participation in eight pollution cases as a Federal appeals court judge violated no laws or judicial ethics guidelines.

"There is nothing more important to me than my integrity," said Judge Breyer, who is expected to be confirmed easily despite this issue.

Nonetheless, Judge Breyer, who is the chief judge of Federal Court of Appeals for the First Circuit, in Boston, said he would do whatever he could to end his association quickly with the Lloyd's of London insurance syndicate. But that would probably be very costly and still might not guarantee that he be free of future liability.

He also told the committee that he did not oppose the death penalty and believed that a woman had a constitutional right to an abortion. He refused, however, to discuss details of how he would interpret specific cases involving those issues that might come before the Court. [Excerpts, page A16.]

Judge Breyer showed his eagerness to address critics when he included the remarks about his Lloyd's investment in a quickly added postscript to his prepared opening statement — before anyone even asked him about it.

"I know that — and this is important to me — that in recent weeks there have been questions raised about the ethical standard that I applied in sitting on certain environmental cases in the First Circuit at a time when I had an investment, an

Continued on Page A17, Column 2

Continued From Page 1

insurance investment, in Lloyd's," he said.

"I have reviewed those cases again, and the judicial recusal statute, and I personally am confident that my sitting in those cases did not present any conflict of interest."

Although the Lloyd's issue was the most pointed one raised today, Judge Breyer was also asked about some emotion-laden legal issues that dominated Supreme Court debate in recent years. He said, for example, that he did not automatically oppose the death penalty, as did Justice Harry A. Blackmun, the man he would replace. But he would not discuss specific circumstances in which he might limit its application.

He noted Justice Blackmun's announcement earlier this year, his 24th year on the Court, that he could no longer vote to approve the death penalty under any circumstances. "I have no such personal view in regard to the death penalty," Judge Breyer told Senator Strom Thurmond, a South Carolina Republican. "The Supreme Court has considered that matter for quite a long time in a large number of cases."

Then, in what seemed a mild criticism of Justice Blackmun, Judge Breyer said he believed that if a Justice had strong personal views on an issue as important as the death penalty "perhaps he should recuse himself."

On abortion, he told Senator Thurmond that the right to abortion was decided 21 years ago in Roe v. Wade and was reaffirmed two years ago in

A nominee's risk — taking the initiative — seems to pay off.

a case from Pennsylvania, Planned Parenthood v. Casey. "That is the law," he said.

As to how far a state may go in restricting abortions, he added, "I don't think I should go into those."

His matter-of-fact answers on both subjects demonstrated how the two issues have receded as centerpieces of the debate over the Supreme Court.

Indeed, most of Judge Breyer's answers involved more esoteric legal issues related to his expertise in government regulation. In a colloquy with Senator Joseph R. Biden Jr., the Delaware Democrat who is chairman of the Judiciary Committee, Judge Breyer said he believed a judge should show great deference to regulations drafted by Federal agencies.

Senator Biden noted that Judge Breyer has written extensively claiming that Federal agencies waste huge amounts of money because of distorted priorities. For example, he has written about a case in which another court struck down the Environmental Protection Agency's ban on asbestos as costly and inefficient.

Senator Biden asked if Judge Breyer agreed that even if agencies may be wasting money, it would be improper for courts to overrule them because of some economic analysis. "Absolutely, absolutely," came the response. Judge Breyer said he used the asbestos case as an illustration "that it isn't a very good idea for courts to get involved in that decision. It's a decision for Congress to make."

Senator Howard M. Metzenbaum, an Ohio Democrat and the only committee member to raise the Lloyd's issue today, said he would question Judge Breyer closely about any possible conflict on Wednesday.

The main focus of this query is Judge Breyer's investment in a 1985 syndicate of Lloyd's, which is facing significant losses because it had insured parties against losses from asbestos and insurance lawsuits.

A Tricky Investment

Because of his Lloyd's investment, Judge Breyer declined to participate in any asbestos case but he did issue opinions in eight cases involving the so-called Superfund, the law enacted by Congress providing money to cleanup toxic waste sites. Over his years on the bench, Judge Breyer has been an investor in dozens of syndicates formed by Lloyd's, but the 1985 syndicate is apparently the only one that remains open with a potential for ever greater losses.

Being an investor in a Lloyd's syndicate was once considered a profitable investment favored by wealthy people who could count on great profits in exchange for pledging all their assets to cover any losses. But in recent years, it has proven to be a highly risky investment; many people have had their fortunes wiped out.

Judge Breyer emphasized today that he thought it was a fair issue for his critics to have raised and suggested that he would regard the ethics discussion as a lesson he would use to make him more sensitive as a judge in the future.

He said he intended to ask the managers of his syndicate, known as Merrett 418, to expedite the termination of his relationship with Lloyd's. But some experts said that could be extremely difficult, if not impossible.

White House officials said that Judge Breyer, might try to buy some reinsurance, that is he could pay someone handsomely to agree to cover his future losses. Judge Breyer has listed his net worth at more than $8 million, largely in stocks, mutual funds and four residences around the world, some of it inherited from his wife's family. If confirmed he would be the Court's wealthiest member.

At the end of the day, Senator Biden said, "I don't see anything, from the esoteric to the ethical, that has caused any red flags to go up."

Senator Orrin G. Hatch of Utah, the committee's ranking Republican, agreed, saying, "I believe he will be confirmed."

3

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HOUSE COMMITTEE ON
SCIENCE AND TECHNOLOGY

Congress of the United States
House of Representatives
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June 23, 1994

The Honorable Thomas S. Foley
Speaker
U.S. House of Representatives
H-204, The Capitol
Washington, D.C. 20515

Dear Mr. Speaker:

This is to respectfully advise you that we all agree that the Nation's health care system needs to be reformed. However, we are unable to support any reform legislation that does not explicitly exclude elective abortion from the scope of any government-defined, government-mandated, or government-funded health benefits package.

As you are aware, President Clinton's original Health Security Act, and its more recent modifications, would establish a "comprehensive benefits package". As the Administration has acknowledged, elective abortion would be covered under the general language describing the benefits package. This means that the bill mandates that all health plans must include abortion facilities and pay for all abortions, and that all working Americans and their employers must pay for unrestricted abortions through their health care premiums.

In addition, the bill extends the federally defined benefits to persons now covered by Medicaid, and to other lower-income groups,using tax funds. If abortion is included in the federal package, this would have the effect of nullifying the Hyde Amendment and the laws of three-fourths of the states that generally prohibit tax-funded abortion.

There are also alternative legislative proposals under which a national commission would decide on the details of a federal benefits package. That system, too, would certainly result in universal, mandatory abortion coverage, because the courts have construed federal laws that provide for general health services (e.g., Medicaid) to cover abortion on request, except where Congress has explicitly excluded abortion.

Therefore, we recognize that it is absolutely necessary for any health care legislation to explicitly exclude abortion from the scope of any benefits package defined by any entity of government.

Any health reform bill must also contain language to prevent it from nullifying the types of state abortion limitations that the Supreme Court has ruled are permitted under the Constitution -- for example; parental consent laws, waiting periods, certain limitations on third-trimester abortions, and prohibitions on abortions by non-physicians. The President's bill, and some of the alternative bills as well, contain multiple provisions that would invalidate such state abortion limitations.

It is our hope that these amendments will be adopted prior to or during floor action on the bill. We will be unable to support any health care bill that does not contain them.

If you would find it constructive to have a meeting on this issue we would be more than willing to meet with you at your convenience. Thank you in advance for your consideration of this very important issue.

Sincerely,

Harold L. Volkmer
Member of Congress

John P. Murtha
Member of Congress

Bill Sarpalius
Member of Congress

Bart Stupak
Member of Congress

Ralph M. Hall
Member of Congress

Frank Tejeda
Member of Congress

Robert A. Borski
Member of Congress

Nick J. Rahall
Member of Congress

Ron Klink
Member of Congress

George E. Sangmeister
Member of Congress

James A. Barcia
Member of Congress

William O. Lipinski
Member of Congress

The Honorable Thomas S. Foley
Page 3

Paul E. Kanjorski
Member of Congress

Collin C. Peterson
Member of Congress

James A. Hayes
Member of Congress

Earl Hutto
Member of Congress

W.J.(Billy) Tauzin
Member of Congress

Gene Taylor
Member of Congress

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Solomon P. Ortiz
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Tim Holden
Member of Congress

Charles W. Stenholm
Member of Congress

Ike Skelton
Member of Congress

E. de la Garza
Member of Congress

Romano L. Mazzoli
Member of Congress

Jerry F. Costello
Member of Congress

Dale E. Kildee
Member of Congress

Douglas Applegate
Member of Congress

Glenn Poshard
Member of Congress

Greg Laughlin
Member of Congress

Alan B. Mollohan
Member of Congress

Robert A. Underwood
Member of Congress

Tony P. Hall
Member of Congress

Austin J. Murphy
Member of Congress

Mike Parker
Member of Congress

Below are some examples of when abortion might be needed to prevent serious health consequences for a pregnant woman. Some relate to women with previous medical conditions; others can happen to any woman (better on the campaign stump!).

(1) A pregnant woman develops a tumor (e.g., such as thyroid cancer or kidney cancer). Without an abortion, she has no option but to delay therapy (since treatment for these cancers would harm the fetus).

(2) A woman with previously diagnosed and treated breast cancer (or malignant melanoma) becomes pregnant. Although the literature is controversial, many women would not want to take the risk that increased hormone levels during pregnancy would cause a recurrence or exacerbation of these tumors.

(3) A woman who developed phlebitis (blood clot in the leg) and had a pulmonary embolism (blood clot to the lung) while on heparin therapy during her last pregnancy becomes pregnant again. Unless she has an abortion she is at great risk of having a recurrent (and possibly fatal) pulmonary embolism.

(4) A woman with diabetes becomes pregnant and develops aggressive proliferative retinopathy (eye disease) or proteinuria (kidney disease) during the first trimester. Unless she has an abortion, she is at risk of becoming blind or going into kidney failure.

(5) A woman with a kidney transplant becomes pregnant. Without an abortion, she is at risk of harming the fetus (since the immunosuppresive drugs are toxic), developing hypertension and losing the kidney, or, if she develops a pregnancy-related complication requiring a C-section, of cutting the circulation to the transplanted kidney and going into kidney failure.

House Committee

Dems: 27
Reps: 17

COMMITTEE ON ENERGY AND COMMERCE

Pro (23)	Mixed (4)	Anti (17)
Dingell D (MI-16)	Klug R (WI-2)	Tauzin
Waxman D (CA-29)	Rowland D (GA-8)	Hall
Markey D (MA-7)	Slattery D (KS-2)	Manton
Swift D (WA-2)	Cooper D (TN-4)	Moorhead
Collins D (IL-7)		Bliley
Synar D (OK-2)		Fields
Wyden D (OR-3)		Oxley
Bryant D (TX-5)		Bilirakis
Boucher D (VA-9)		Schaefer
Towns D (NY-10)		Barton
Studds D (MA-10)		McMillan
Lehman D (CA-19)		Hastert
Pallone D (NJ-6)		Upton
Washington D (TX-18)		Stearns
Schenk D (CA-49)		Paxon
Kreidler D (WA-9)		Gillmor
Margolies-Mezvinsky D (PA-13)		Crapo
Lambert D (AR-1)		
Sharp D (IN-2)		
Richardson D (NM-3)		
Brown S (OH-13)		
Franks R (CT-5)		
Greenwood R (PA-8)		

NARAL
March 17, 1994

House Committtee

Dems: 15
Reps: 9

COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT

Pro (13)	Mixed (4)	Anti (7)
Waxman D (CA-29)	Klug R (WI-2)	Hall
Synar D (OK-2)	Cooper D (TN-4)	Bliley
Wyden D (OR-3)	Slattery D (KS-2)	Bilirakis
Bryant D (TX-5)	Rowland D (GA-8)	McMillan
Towns D (NY-10)		Hastert
Studds D (MA-10)		Upton
Washington D (TX-18)		Paxon
Pallone D (NJ-6)		
Kreidler D (WA-9)		
Richardson D (NM-3)		
Brown D (OH-13)		
Franks R (CT-5)		
Greenwood R (PA-8)		
Dingell D (MI-16)		Moorhead

NARAL

House Committee

Dems: 7
Reps: 4

COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

Pro (7)	Mixed (1)	Anti (3)
Stark D (CA-13)	Kleczka D (WI-4)	Thomas
Levin D (MI-12)		McCrery
Cardin D (MO-3)		Grandy
Andrews D (TX-25)		
McDermott D (WA-7)		
Lewis D (GA-5)		
Johnson R (CT-6)		

NARAL

House Committee

Dems: 24
Reps: 14

COMMITTEE ON WAYS AND MEANS

Pro (17)	Mixed (6)	Anti (15)
Pickle D (TX-10)	Rostenkowski D (IL-5)	Jacobs
Rangel D (NY-15)	Gibbons D (FL-11)	Neal
Stark D (CA-13)	Kleczka D (WI-4)	McNulty
Ford D (MI-13)	Payne D (VA-5)	Archer
Matsui D (CA-5)	Houghton R (NY-31)	Crane
Kennelly D (CT-1)	Brewster D (OK-3)	Thomas
Coyne D (PA-14)		Shaw
Andrews D (TX-11)		Sundquist
Levin D (MI-12)		Bunning
Cardin D (MD-3)		Grandy
McDermott D (WA-7)		Herger
Lewis D (GA-5)		McCrery
Kopetski D (OR-5)		Hancock
Jefferson D (LA-2)		Santorum
Reynolds D (IL-2)		Camp
Johnson R (CT-6)		
Hoagland D (NE-2)		

NARAL

House Committee

Dems: 27
Reps: 15

COMMITTEE ON EDUCATION AND LABOR

Pro (19)	Mixed (8)	Anti (15)
Ford D (MI-13)	Green D (TX-29)	Murphy
Clay D (MO-1)	Romero-Barcelo D (PR)	Kildee
Miller D (CA-7)	de Lugo D (VI)	Roemer
Williams D (MT-AL)	Faleomavaega D (AS)	Klink
Martinez D (CA-31)	Baesler D (KY-6)	Goodling
Owens D (NY-11)	Roukema R (NJ-5)	Petri
Sawyer D (OH-14)	Fawell R (IL-13)	Gunderson
Payne D (NJ-10)	Castle R (DE-AL)	Armey
Unsoeld D (WA-3)		Miller (FL)
Mink D (HI-2)		Ballenger
Andrews D (NJ-1)		Barrett
Reed D (RI-2)		Boehner
Engel D (NY-17)		Cunningham
Becerra D (CA-30)		Hoekstra
Scott D (VA-3)		McKeon
Woolsey D (CA-6)		
English D (AZ-6)		
Strickland D (OH-6)		
Molinari R (NY-13)		

NARAL

Senate Committee

Dems: 10
Reps: 7

COMMITTEE ON LABOR AND HUMAN RESOURCES

Pro (9)	Mixed (3)	Anti (5)
Kennedy (D-MA)	Bingaman (D-NM)	Coats
Pell (D-RI)	Wofford (D-PA)	Gregg
Metzenbaum (D-OH)	Kassebaum (R-KS)	Thurmond
Dodd (D-CT)		Hatch
Simon (D-IL)		Durenberger
Harkin (D-IA)		
Mikulski (D-MD)		
Jeffords (R-VT)		
Wellstone (D-MN)		

NARAL

Senate Committee

Dems: 11
Reps: 9

COMMITTEE ON FINANCE

Pro (8)	Mixed (4)	Anti (8)
Moynihan (D-NY)	Boren (D-OK)	Dole
Baucus (D-MT)	Pryor (D-AR)	Roth
Bradley (D-NJ)	Daschle (D-SD)	Danforth
Mitchell (D-ME)	Conrad (D-ND)	Durenberger
Riegle (D-MI)		Grassley
Rockefeller (D-WV)		Hatch
Packwood (R-OR)		Wallop
Chafee (R-RI)		Breaux

NARAL

MEMORANDUM

To : Jennifer Klein

From : Jim Mays

Subject : Abortion Rider Comments

Copy : Ken Thorpe

1. Base cost - abortions may represent $5 per contract - something less than 0.2% of the premiums.

2. Moving to a rider - if a check-off resulted in 75% of enrollees declining coverage, the coverage cost would be about $20 per contract, less if adverse selection is imperfect.

3. Administratively, this should not be a big complication. It requires one more data item on each contract, and it requires the plans to check the enrollment file after an abortion to see if a bill needs to be sent to the enrollee.

abridl
/a/p

Confidential

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To Jennifer Klein	From Jim Mays
Co.	Co.
Dept.	Phone # 703-941-7400
Fax # 202-456-2878	Fax #

SUBCOMMITTEE ON
HEALTH AND THE
ENVIRONMENT

FAX COVER SHEET

2415 Rayburn Building
Washington, D.C. 20515

Phone: 202-225-4952
Fax: 202-225-3043

From the Desk of

Kristen Ebeler
Mike Hash
Alan Schlobohm
~~Andy Schneider~~
Tim Westmoreland

2424 Rayburn Building
Washington, D.C. 20515

Phone: 202-225-0130
Fax: 202-225-7090

From the Desk of

Ruth Katz
Anne Lebbon
Karen Nelson

Attention:	Jennifer Klein
Organization:	

Phone:

Fax:

Pages Following
Cover Sheet:

Message:

As discussed.

Tom

Talking Points Regarding Coverage of Abortion Services Through a Rider to Basic Benefits

Summary: Some people have proposed that abortion services be financed only through a supplemental insurance policy that is paid for separately as a rider. We believe that such a proposal is bad precedent, undercuts current private insurance coverage, and is unworkable.

Abortion is a legal medical procedure. It should not be treated differently from other legal medical procedures.

Allowing people to opt out of subsidizing services to which they object is a bad precedent for an insurance plan. There are other services to which some people object (e.g., contraception, infertility, care for drug abusers, or (in an extreme case) payment by Christian Scientists for any procedures. In analagous instances, the government requires Quakers to subsidize the Defense Department or home schooling parents to subsidize schools.

No health reform plan proposes direct payment for abortion services; all plans merely provide Federal subsidies for the purchase of insurance. Current tax law treatment of health insurance "indirectly subsidizes" abortion with Federal funds. Indirect subsidies under health reform are no different.

Most private insurance policies now cover abortion services. Currently insured women should not be asked to give up their insurance as part of health reform.

Two-thirds of all private insurance (whether fee-for-service or HMO) routinely cover abortion; another 20-25% of plans cover abortion with some medical restrictions.

Only 10-15% of all private insurance plans provide no abortion coverage.

A separate rider for abortion services is unworkable.

Abortion services are usually for unintended pregnancies or for pregnancies in which there are unexpected consequences (such as severe complications or severe fetal defects). Since people do not expect to need the abortion service, people will not insure against it.

If only people who expect to have abortions buy a rider, the premium for such insurance will be almost as high as the cost of paying for the abortion itself. This is effectively no insurance.

Abortion Services

Abortion is legal. The decision about whether to have one should be made by a woman and her doctor. The government shouldn't get in the middle of that private decision.

Abortion Coverage

Most private insurance policies now cover abortion services. Women should not be asked to give up the insurance that they have.

Two-thirds of all private insurance (whether fee-for-service or HMO) routinely cover abortion. Only 10-15% of all private insurance plans provide no abortion coverage.

Abortion and Federal Funds

Current private insurance plans--including the 85 to 90% of plans that provide abortion services--get tax subsidies now.

The Clinton Plan relies on private health care plans that get Federal subsidies for small businesses and self-employed people. There is no specific Federal funding of abortion.

Abortion and the Conscience Clause

Doctors and nurses should be allowed to refuse to perform abortions because of their own religious views, and the Clinton bill says that.

But a woman should be guaranteed that if she and her doctor say she needs an abortion, no insurance company is going to get in the middle and say no.

News

A Not-for-Profit Corporation
for Reproductive Health
Research, Policy Analysis
and Public Education
120 Wall Street
New York, NY 10005

The Alan Guttmacher Institute
New York and Washington

Contact: Susan Tew/Carol Selton/Beth Fredrick
212/248-1111

EMBARGOED FOR RELEASE:
WED., MARCH 9, 1994 — 2:00 P.M.

ABORTION AND STERILIZATION BETTER COVERED THAN CONTRACEPTION BY THE MAJORITY OF INSURANCE PLANS

Two-thirds of typical fee-for-service insurance plans routinely cover abortion, and nine in 10 routinely cover sterilization, according to a new study by The Alan Guttmacher Institute (AGI). In sharp contrast, reflecting the traditional bias of private health insurance toward coverage of surgical services but not of preventive care, half of all typical fee-for-service plans provide no contraceptive coverage at all. Only 15% cover all five of the most effective medical family planning methods—Norplant implants, Depo-Provera, the IUD, oral contraceptives and the diaphragm. Furthermore, only 22% of plans routinely cover contraceptive counseling.

While coverage of sterilization and abortion services by health maintenance organizations (HMOs) is similar to that of indemnity plans, contraceptive coverage is considerably better. Only 7% of HMOs provide no coverage, four in 10 typically cover all five medical family planning methods, and nearly all cover contraceptive counseling.

These are among the initial findings from the first large-scale examination of private insurance coverage of reproductive health care services essential during women's childbearing years, currently being conducted by AGI. It addresses three critical areas: whether specific services are covered, provisions for patients to obtain confidential care, and the ease with which services can be accessed in a managed-care environment.

Portions of the study—pertaining only to the extent to which specific services are covered—are being released Wednesday, March 9 in testimony at a special Congressional hearing of the Senate Labor and Human Resources Committee convened by Senator Barbara Mikulski (D-MD). These key findings are:

- Nearly 90% of typical plans—written by commercial companies, Blue Cross-Blue Shields or HMOs—routinely cover surgical sterilization services.
- Two-thirds of typical plans routinely cover surgical abortion services, whether written by commercial companies, Blue Cross-Blue Shields or HMOs.

- - more - -

The remaining one-third either do not cover abortion services at all (10-15%) or restrict coverage, most often by requiring certification of a specific medical indication for the procedure (20-25%).

- Coverage of reversible contraceptives is meager in conventional fee-for-service policies. Half of plans typically do not cover any reversible contraceptive method (59% of commercial companies and 36% of Blue Cross-Blue Shields). Only 15% cover all five of the most effective medical methods (8% of companies and 24% of Blue Cross-Blue Shields). Only one-third cover oral contraceptives.

  HMOs provide somewhat more comprehensive coverage; only 7% of HMOs provide no contraceptive coverage at all, and 40% cover all five methods. Eighty-four percent of HMOs routinely cover oral contraceptives.

- Counseling and risk assessment services are even less likely to be covered in conventional fee-for-service plans; less than one-quarter routinely cover contraceptive counseling (13% of companies and 33% of Blue Cross-Blue Shields) and well under half routinely cover preconception risk assessment. In contrast, these services are routinely covered by at least 90% of HMOs.

"What emerges from these findings is a portrait of private insurance coverage that is antiquated in its bias toward surgical care over nonsurgical procedures, curative care over preventive care and medical procedures over counseling and education. These patterns of coverage leave women with little or no coverage for key services they need during their childbearing years," comments Jeannie Rosoff, AGI's president. "Our emerging national health care reform plan must not model itself on current capricious patterns of coverage that simply don't address the needs and circumstances of women and couples today."

AGI's study, funded by The Robert Wood Johnson Foundation, is based on a 1993 survey of the 100 largest commercial insurance companies (based on their net premiums written), all 73 Blue Cross/Blue Shield plans and 213 HMOs. Respondents included 58% of the commercial companies, 53% of the Blue Cross/Blue Shield plans and 50% of the HMOs surveyed.

Detailed information on other areas examined in the study, as well as coverage of other services (such as routinely gynecological care, infertility and maternity care) will be presented in the full report to be published in mid-1994.

###

The Alan Guttmacher Institute is a not-for-profit corporation for reproductive health research, policy analysis and public education, with offices in New York and Washington, D.C.

Percent of typical plans in which specific service is not covered, by type of plan

Service	Conventional Indemnity Plans, by size of group			Preferred Provider Organizations *	Health Maintenance Organizations *
	Insured Plans <100 Employees	Insured Plans >100 Employees	Self-insured Plans*		
Prescription Drugs	3	3	2	1	11
Medical Devices	9	8	2	6	17
Contraceptive Sterilization					
Laparoscopic tubal ligation	10	10	9	10	7
Vasectomy	11	11	9	10	7
Induced Abortion					
Dilation and curettage/suction aspiration	15	11	14	13	10
Dilation and evacuation	16	11	14	14	10
Reversible Contraception					
IUD insertion	77	74	75	75	14
Diaphragm/cervical cap fitting	80	78	79	77	19
Norplant insertion	74	72	70	71	39
Norplant removal	64	64	61	62	35
DMPA (Depo Provera) injection	62	57	63	58	20
Diaphragm device	85	85	84	83	48
IUD device	84	82	80	79	53
Norplant device	77	76	79	73	54
Oral contraceptives	60	58	52	52	14
Counseling and Risk Assessment					
Contraceptive counseling	77	78	84	76	4
Preconception risk assessment	57	53	60	54	7

*Includes plans of all sizes.

Percent of typical plans in which specific service is covered subject to additional restrictions, by type of plan

Service	Conventional indemnity Plans, by size of group			Preferred Provider Organizations *	Health Maintenance Organizations *
	Insured Plans <100 Employees	Insured Plans >100 Employees	Self- Insured Plans *		
Prescription drugs	NA	NA	NA	NA	NA
Medical devices	NA	NA	NA	NA	NA
Contraceptive Sterilization					
Laparoscopic tubal ligation	4	4	5	4	8
Vasectomy	4	4	5	4	6
Induced Abortion					
Dilation and curettage/suction aspiration	21	23	18	20	20
Dilation and evacuation	18	20	18	19	20
Reversible Contraception					
IUD insertion	0	0	0	0	0
Diaphragm/cervical cap fitting	1	1	0	0	0
Norplant insertion	0	0	0	0	3
Norplant removal	6	4	4	4	7
DMPA (Depo Provera) injection	4	4	5	7	6
Diaphragm device	0	0	0	0	0
IUD device	0	0	0	0	0
Norplant device	0	0	0	0	3
Oral contraceptives	8	8	11	7	2
Counseling and Risk Assessment					
Contraceptive counseling	1	0	0	0	0
Preconception risk assessment	3	4	2	4	3

* Includes plans of all sizes.

Percent of typical plans in which specific service is routinely covered, by type of plan

Service	Conventional indemnity Plans, by size of group			Preferred Provider Organizations *	Health Maintenance Organizations *
	Insured Plans <100 Employees	Insured Plans >100 Employees	Self-insured Plans*		
Prescription drugs	97	97	98	99	89
Medical devices	91	92	98	94	83
Contraceptive Sterilization					
Laparoscopic tubal ligation	86	86	86	86	86
Vasectomy	85	85	86	86	88
Induced Abortion					
Dilation and curettage/suction aspiration	64	66	68	67	70
Dilation and evacuation	66	69	68	67	70
Reversible Contraception					
IUD insertion	23	26	25	25	86
Diaphragm/cervical cap fitting	19	21	21	23	81
Norplant insertion	26	28	30	29	59
Norplant removal	30	32	36	33	58
DMPA (Depo Provera) injection	34	39	32	35	74
Diaphragm device	15	15	16	17	52
IUD device	16	18	20	21	47
Norplant device	23	24	27	27	44
Oral contraceptives	32	33	38	41	84
Counseling and Risk Assessment					
Contraceptive counseling	22	22	16	24	96
Preconception risk assessment	40	43	38	42	90

*Includes plans of all sizes.

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Facsimile Cover Sheet

TO: Jennifer Klein

FROM: Heather Howard

The following number of sheets have been transmitted,

Excluding this page: 4

If there are any problems, please contact he

at (202) 225-6506.

Comments: Jennifer - here are some points I have put together in the past for Cong. Lowey — I hope some of it helps. Let me know if you need anything else —

Heather

QUESTION: WHEN IT COMES TO REPRODUCTIVE HEALTH, SOME WILL ARGUE THAT IT IS A HUGE EXPANSION OF INSURANCE COVERAGE AND WILL ENCOURAGE WOMEN TO GET ABORTIONS. IS THAT THE CASE MRS. LOWEY?

ANSWER: WITH REGARD TO ABORTION, ABSOLUTELY NOT. THE VAST MAJORITY OF PRIVATE PLANS CURRENTLY COVER ABORTIONS AND RECOGNIZE THAT ABORTION IS A BASIC PART OF THE FULL RANGE OF REPRODUCTIVE HEALTH SERVICES THAT SHOULD BE AVAILABLE. THEREFORE, EXCLUDING COVERAGE OF ABORTION SERVICES WOULD TAKE AWAY A BENEFIT WOMEN CURRENTLY HAVE.

ALSO, THOUGH, IT IS IMPORTANT FOR US TO NOTE THAT THE REAL EXPANSION OF COVERAGE IN THE PLAN IS THE COVERAGE OF FAMILY PLANNING SERVICES, WHICH WILL MAKE ABORTIONS LESS NECESSARY. PRIVATE PLANS DO NOT TRADITIONALLY COVER CONTRACEPTIVE SERVICES, AND AS A RESULT WOMEN HAVE HIGHER OUT OF POCKET COSTS FOR HEALTH CARE OR DO NOT HAVE ACCESS TO THESE VITAL SERVICES. COVERAGE OF FAMILY PLANNING SERVICES IS A VITAL STEP TOWARDS IMPROVING MATERNAL AND CHILD HEALTH AND TOWARDS REDUCING THE NEED FOR ABORTIONS, A GOAL ON WHICH WE CAN ALL AGREE.

QUESTION: CAN YOU REALLY PROVE THAT THE MAJORITY OF PRIVATE PLANS COVER ABORTIONS?

ANSWER: YES, THE RECENTLY-ANNOUNCED STUDY BY THE ALAN GUTTMACHER INSTITUTE SHOWS THAT 2/3 OF PRIVATE PLANS ROUTINELY COVER ABORTIONS. (SEE AGI STUDY)

QUESTION: THE AMERICAN PEOPLE DON'T REALLY WANT ABORTION COVERAGE DO THEY?

QUESTION: WON'T THE CLINTON PLAN FORCE AMERICANS TO PARTICIPATE IN ABORTIONS THEY ARE MORALLY OPPOSED TO?

ANSWER: THE HEALTH SECURITY ACT HAS A CONSCIENCE CLAUSE THAT EXEMPTS ALL PROVIDERS AND INSTITUTIONS THAT ARE MORALLY OPPOSED.

QUESTION: WOULDN'T THE CLINTON PLAN FORCE AN EMPLOYER WHO IS CONSCIENTIOUSLY OPPOSED, FOR EXAMPLE THE CATHOLIC CHURCH, TO PAY FOR ABORTIONS FOR ITS EMPLOYEES?

ANSWER: WELL, THE IMPORTANCE OF A BASIC BENEFITS PACKAGE IS ENSURING THAT EVERYONE HAS ACCESS TO THE SAME SERVICES -- EMPLOYERS SHOULD NOT BE ABLE TO PICK AND CHOOSE WHICH SERVICES ARE AVAILABLE TO THEIR EMPLOYEES. ABORTION IS PART OF WOMEN'S BASIC HEALTH CARE AND SHOULD BE COVERED AS PART OF A BROAD RANGE OF REPRODUCTIVE HEALTH SERVICES. THIS DECISION SHOULD BE

DECIDED BY A WOMAN AND HER PHYSICIANS, NOT HER EMPLOYER.

ALSO, LET'S NOT FORGET THAT SEVERAL RELIGIOUS ARGUMENTS COULD BE RAISED, SUCH AS JEHOVAH'S WITNESSES WHO ARE OPPOSED TO BLOOD TRANSFUSIONS, OR CHRISTIAN SCIENTISTS WHO REJECT MEDICAL INTERVENTION. ADDITIONALLY, THE CATHOLIC CHURCH IS OPPOSED TO FAMILY PLANNING. WHERE CAN WE DRAW THE LINE?

QUESTION: DOESN'T THE CLINTON PLAN FORCE TAXPAYERS TO PAY FOR ABORTIONS?

ANSWER: THE HEALTH SECURITY ACT IS BASED ON PRIVATE INSURANCE. AS WITH MOST WOMEN'S CURRENT COVERAGE, PEOPLE WILL PAY PREMIUMS FOR COVERAGE OF A BASIC BENEFITS PACKAGE THAT INCLUDES ABORTION. THE FEDERAL GOVERNMENT WILL NOT BE PAYING DIRECT REIMBURSEMENT FOR SERVICES, BUT RATHER WILL SUBSIDIZE THE PREMIUM TO ALLOW POOR WOMEN TO PURCHASE <u>PRIVATE</u> INSURANCE. IN THIS SENSE, THE ISSUE IS VERY SIMILAR TO THE FEDERAL EMPLOYEES ISSUE -- DON'T FORGET THAT CONGRESS VOTED TO ALLOW ABORTION AS A BENEFIT IN THE FEDERAL EMPLOYEE HEALTH PLAN.

QUESTION: WHAT ABOUT A RIDER? DOESN'T THIS PRESERVE THE OPTION FOR WOMEN BUT ALLOW THOSE WHO ARE OPPOSED A WAY OUT?

ANSWER: SOME HAVE FLOATED THE IDEA OF AN ABORTION "RIDER." THIS IS TOTALLY UNACCEPTABLE AND A NON-STARTER. THE MAJORITY OF WOMEN ACROSS AMERICA CURRENTLY HAVE COVERAGE FOR ABORTION SERVICES, YET SOME WOULD SINGLE THIS SERVICE OUT AND DISCRIMINATE AGAINST WOMEN'S CHOICES. IT IS OFFENSIVE TO WOMEN TO FORCE THEM TO FORESEE NEEDING AN ABORTION. IT WOULD ALSO BE AN ADMINISTRATIVE NIGHTMARE TO IMPLEMENT -- WOULD YOU HAVE SEVERAL DIFFERENT ACCOUNTS? IT IS CLEARLY UNWORKABLE.

WHY SHOULD ABORTION BE INCLUDED IN HEALTH CARE REFORM

NOT COVERING ABORTIONS WOULD BE A STEP BACKWARDS

- CURRENTLY, THE VAST MAJORITY OF PRIVATE PLANS COVER ABORTIONS. FOR EXAMPLE, ALMOST ALL BLUE CROSS/BLUE SHIELD PLANS INCLUDE ABORTION. TO NOT COVER ABORTIONS WOULD BE A STEP BACKWARDS FOR MOST AMERICAN WOMEN.

THIS IS NOT ABOUT ABORTIONS - IT IS ABOUT IMPROVING WOMEN'S HEALTH CARE

- WE HAVE AN OPPORTUNITY TO REVOLUTIONIZE OUR HEALTH CARE DELIVERY SYSTEM, TO ENSURE THAT WOMEN'S HEALTH CARE NEEDS ARE NO LONGER IGNORED, AND YET SOME WANT TO OBSESS ABOUT ABORTION. THIS SHOULDN'T BE ABOUT ABORTION - IT SHOULD BE ABOUT PROVIDING WOMEN THE FULL RANGE OF REPRODUCTIVE HEALTH SERVICES.

- IN THE CONTEXT OF MAINTAINING WOMEN'S HEALTH ABORTION IS JUST ONE COMPONENT -- I WANT TO ENSURE ACCESS TO FAMILY PLANNING SERVICES, TO SCREENINGS FOR REPRODUCTIVE CANCERS AND STD'S, AND COMPREHENSIVE PRE-AND POST-NATAL CARE.

- ADDITIONALLY, WHAT THE PRESIDENT'S PLAN WILL DO IS ALREADY COMMON PRACTICE - MOST INSURANCE PLANS CONSIDER ABORTION A PART OF A COMPREHENSIVE REPRODUCTIVE HEALTH CARE PACKAGE. INCLUDING ABORTION IN THE HEALTH CARE REFORM PLAN WILL NOT BE A RADICAL MOVE AS SOME PORTRAY IT. **TO DO OTHERWISE WOULD ACTUALLY BE THE RADICAL MOVE - AND WOULD BE A REDUCTION IN BENEFITS FOR ALL AMERICAN WOMEN.**

- WHERE DO YOU THEN DRAW THE LINE? DO YOU NOT INCLUDE FAMILY PLANNING SERVICES, WHICH ARE CRITICAL IN PREVENTING UNINTENDED PREGNANCIES?

NOT COVERING ABORTIONS WOULD EXACERBATE PHYSICIAN SHORTAGE PROBLEM

- ENSURING COVERAGE OF ABORTIONS WILL PUT THE ABORTION PROCEDURE BACK WHERE IT SHOULD BE -- IN THE MEDICAL MAINSTREAM. EXCLUSION OF ABORTION WOULD LEAD TO THE FURTHER OSTRACIZING OF ABORTION SERVICES. IF IT IS RELEGATED TO OUTSIDE THE SYSTEM, EVEN FEWER PHYSICIANS WOULD PROVIDE THE SERVICES, LEADING TO MUCH REDUCED ACCESS AND WOULD JEOPARDIZE WOMEN'S HEALTH OPTIONS. FOR EXAMPLE, CURRENTLY THERE IS ONLY ONE PROVIDER IN BOTH NORTH DAKOTA AND SOUTH DAKOTA, AND 83% OF ALL COUNTIES HAVE NO ABORTION PROVIDERS.

WHY SHOULD THE GOVERNMENT PAY FOR ABORTIONS FOR POOR WOMEN?

- OUR CURRENT SYSTEM IS A CHECKERBOARD OF REPRODUCTIVE HEALTH

SERVICES FOR POOR WOMEN -- DEPENDING ON WHERE YOU LIVE, YOU MAY HAVE ACCESS TO THE FULL RANGE OF SERVICES. ENSURING ACCESS FOR POOR WOMEN WILL MEAN AN END TO OUR CURRENT TWO-TIERED SYSTEM OF HEALTH CARE, AND WILL GUARANTEE THAT POOR WOMEN HAVE THE SAME FUNDAMENTAL RIGHT TO CHOOSE THAT OTHER WOMEN DO. IT IS CLEAR THAT IF YOU DO NOT HAVE ACCESS TO SERVICES, THEN THE LEGAL RIGHT TO CHOOSE IS MEANINGLESS.

- LET'S NOT FORGET THAT WE ARE TALKING ABOUT A PRIVATE INSURANCE SYSTEM. UNDER THE PRESIDENT'S PLAN, INDIVIDUALS WILL PAY A PREMIUM FOR INSURANCE COVERAGE -- THEY WILL BE CONTRIBUTING TO THEIR OWN COVERAGE, MUCH AS HOW PRIVATE PLANS WORK. THIS IS VERY SIMILAR TO THE TREASURY-POSTAL SITUATION, WHICH WE WON LAST YEAR.

- THE BENEFITS PACKAGE IS A COMPREHENSIVE PACKAGE PROVIDING MANY SERVICES THAT WON'T BE USED BY EVERYONE. THE POINT IS TO MAKE AVAILABLE MEDICAL SERVICES TO THOSE WHO NEED IT OR CHOOSE TO USE IT. NO INDIVIDUAL PROVIDER OR HOSPITAL SHOULD BE REQUIRED TO PARTICIPATE IN ABORTIONS IF THEY ARE CONSCIENTIOUSLY OPPOSED.

CONGRESSIONAL CAUCUS FOR WOMEN'S ISSUES

PHONE: (202) 225-6740
FAX: (202) 225-2593

TO: Jennifer Klein DATE: 3/23/94

FAX:

NUMBER OF TOTAL PAGES: 3

FROM:

- ☐ Lesley Primmer
- ☐ Wendy Siporen
- ☒ Susan Wood
- ☐ Leah Hill
- ☐ Marjorie Sims
- ☐ _____

COMMENTS:

As we discussed yesterday – here are talking pts that were developed earlier this year.

Congressional Caucus for Women's Issues

Talking points on inclusion of abortion in the comprehensive benefits package

1) Abortion services are currently covered by most private plans, and the federal government should not take away benefits already available to most Americans. Exclusion of abortion services from the benefits package would deny all women access to abortion -- not just poor women. The real expansion of benefits is adding coverage of contraception services -- which has not been traditionally covered by private insurance. Increasing access to family planning services will reduce the incidence of unwanted pregnancy -- a goal that everyone should support.

2) Abortion services does not add to the cost of an insurance plan if included as part of the package; As part of a comprehensive benefit, the cost is negligible. However costs of a separate rider may be prohibitive. In fact, exclusion of abortion services may lead to increased costs, because of the expense of labor, delivery, and increased social services to care for an unwanted child, etc.

3) Subsidy of a health-care premium for low-income families is not the same as direct reimbursement to a health provider for abortion services. The federal government is not paying for abortions for low-income women, but is subsidizing the premium to allow the woman to purchase private health insurance. The insurance plan reimburses providers for medically appropriate services. (This argument is that same as the one that was made for the Federal Employment Health Benefits Plan, which passed Congress this year without the ban on private health plans on covering abortion services in plans offered to federal employees.) Subsidy of abortion already exists through the tax deductions allowed for employers who provide health care benefits.

4) Abortion services should be treated the same as other medical services, leaving the decision of having an abortion between the woman and her doctor. State laws regarding parental notification/consent, and other constitutionally permissible restrictions would still apply.

5) The benefits package is a comprehensive package providing many services that will not be used by everyone. The point is to make available medical services to those who need it or choose to use it. No individual

provider or facility would be required to participate in abortion or any other procedure if they are conscientiously opposed, but plans would have to ensure that all benefits (including contraceptive services and abortion) are available to enrollees.

6) Religious arguments against a benefit could be raised by others, such as Jehovah's Witnesses who are opposed to blood transfusions, or Christian Scientists who reject many medical interventions. Maintenance of life or allowing people with terminal illnesses to die are also issues which are extremely controversial, but should not be determined by the insurance plan. The principle remains the same: everyone has access to a comprehensive benefits package and individuals do not have to use benefits that they are opposed to.

7) Exclusion of abortion would lead to further ostracizing of abortion services. If virtually all medical services are covered by insurance, but abortion is not, then doctors, other health providers, and facilities will have no incentive to provide the service. It will be relegated to outside the system, leading to much reduced access. Similarly, if states were allowed to exclude abortion services from coverage in their state, then access within that state would be limited and women would be forced to travel out-of-state. This would compound problems that we already face -- 83% of all counties have no abortion provider.

8) Many of the women elected to Congress were elected because of their strong pro-choice position. Health care reform, and the inclusion of comprehensive reproductive health services, may be the most important pro-choice legislation – because of it's long-term impact on access to abortion services.

□CHA-HUGHES April 12, 1994 (560 words) With photo sent March 25.
XXXN
□BISHOP CRITICIZES CHA OFFICIAL'S TALK AS 'AFFRONT' TO PRO-LIFERS
□By Nancy Frazier O'Brien
□Catholic News Service

o WASHINGTON (CNS) -- A speech by a representative of the Catholic Health Association praising President Clinton's health care reform plan was ''an affront to all those who believe in the sanctity of human life,'' says Bishop Edward T. Hughes of Metuchen, N.J.

o In a letter to John E. Curley Jr., president of the St. Louis-based CHA, Bishop Hughes said the organization ''has a most serious responsibility to disown'' a March 23 talk by Sister Bernice Coreil at a White House ceremony. The bishop sent a copy of his March 31 letter to Catholic News Service.

o Sister Coreil, senior vice president for system integration of the Daughters of Charity National Health System in St. Louis, made no mention of abortion in her five-minute talk to some 200 health care providers. President Clinton, first lady Hillary Rodham Clinton, Vice President Al Gore and his wife, Tipper, all attended the gathering on the White House's South Lawn.

o ''Mr. President, your leadership has kept the flame of health care reform burning brightly in spite of opponents' efforts to douse it with a torrent of negativism,'' said Sister Coreil, a Daughter of Charity who chairs CHA's Leadership Task Force on National Health Policy Reform.

o Clinton later thanked Sister Coreil for her ''stouthearted defense of our continuing efforts.''

o The health care reforms proposed by Clinton would provide all legal U.S. residents with a comprehensive package of medical benefits that includes coverage of abortion.

o ''While it is perfectly appropriate and in accord with the approach of the bishops for Sister to emphasize that the health care reform plan should include universal coverage, it is highly offensive to praise President Clinton for his program for health care reform, when that program includes abortion coverage,'' Bishop Hughes wrote to Curley.

o ''What I find disgraceful is the unbalanced and unreasonable praise of a president and a program that proposes to kill innocent unborn children,'' he added.

o ''While I can speak officially only for my own diocese, I can assure you that such statements and presentations will surely drive a wedge between the Catholic Health Association and the National Conference of Catholic Bishops,'' Bishop Hughes said.

o In a four-page response to the bishop April 11, Curley said the Catholic Health Association has made its opposition to abortion coverage in health care reform ''repeatedly and unequivocally clear to the White House, to the Congress and to the national press.''

o He listed many instances in which CHA told Congress or the White House about its opposition to abortion coverage, including testimony delivered Oct. 14, 1993, by Sister Coreil to the House Energy and Commerce Committee's health subcommittee.

o But, Curley said, some who join the church in opposing abortion coverage do not agree with its support for universal coverage.

''Some would even use the abortion issue cynically to drive a wedge between the proponents of universal coverage and thereby hope to undermine legislative support for that goal,'' he added.

o ''CHA's support for comprehensive health care reform legislation and many components of President Clinton's Health Security Act has not diminished in any way our determination that abortion coverage be excluded from health care reform legislation,'' Curley said. ''We believe that the inclusion of abortion in health care reform would be a moral tragedy and a political mistake.''

END

The Alan Guttmacher Institute
New York and Washington

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for Reproductive Health
Research, Policy Analysis
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March 30, 1994

Melanne Verveer
Deputy Assistant to the President
and Deputy Chief of Staff to the
First Lady
1600 Pennsylvania Ave NW
Washington, DC 20500

Dear Ms. Verveer:

As Congress begins in earnest to draft health care reform legislation, I thought you would be interested in the initial findings of a study currently being conducted by The Alan Guttmacher Institute (AGI). Funded by a grant from The Robert Wood Johnson Foundation, the study is the first large-scale examination of private health insurance coverage of reproductive health care services essential during women's childbearing years.

Initial findings of the study were presented in the enclosed testimony delivered by Jeannie I. Rosoff, President of AGI, before the Senate Committee on Labor and Human Resources on March 9. Among the key findings are the following:

- In line with a longstanding tradition of health insurance to cover surgical services, nearly 90% of typical insurance plans -- whether written by commercial companies, Blue Cross/Blue Shields or HMOs -- routinely cover sterilization, and two-thirds cover abortion. (The remaining one-third either do not cover abortion at all (10-15%) or place additional restrictions on that coverage, most often by requiring certification of a special medical indication for the procedure (20-25%).)

- In contrast, but in line with the traditional bias of health insurance against preventive care, coverage of reversible contraceptives is meager in conventional fee-for-service policies. Half of typical plans do not cover any reversible contraceptive method. Only 15% cover all five of the most effective medical methods, and only one-third cover oral contraceptives. HMOs provide somewhat more comprehensive coverage; 7% of HMOs provide no contraceptive coverage at all, and 40% cover all five methods.

- Coverage of counseling and risk assessment services follows a similar pattern. Less than one-quarter of conventional fee-for-service plans routinely cover contraceptive counseling and well under half routinely cover preconception risk assessment. In contrast, at least 90% of HMOs routinely cover these services.

These findings have important implications as Congress writes legislation to reform our health care system:

- Even as we take steps to extend to people important coverage they do not now have, we should not take away coverage -- such as the coverage of abortion or sterilization -- that is already widespread.

- Coverage of family planning must be significantly improved. To expand current coverage, we need to be more specific than is currently the case in the administration's plan. For example, the Clinton plan relies on the general coverage of prescription drugs to assume coverage of oral contraceptives. Our study indicates that such an assumption is unwarranted: two-thirds of plans that cover prescription drugs nonetheless do not routinely cover oral contraceptives.

- Family planning should be recognized as the preventive service it is. Its role in reducing unintended pregnancy, and hence the need for abortion as well as our unacceptably high levels of infant mortality, is undeniable. The failure of the Clinton plan to formally designate family planning as a preventive service leaves family planning -- alone among preventive services -- subject to deductibles and copayments.

Additional findings of this study will involve the coverage of other important reproductive health care services -- including routine gynecological care, infertility services and maternity care -- and address such key issues as the ease of access through managed-care systems and confidentiality. The full report of this project will be issued mid-year, and will be sent to you upon completion.

Meanwhile, I hope the enclosed testimony is helpful to you. Please feel free to contact the project's principal investigators, Rachel Benson Gold or Daniel Daley, at 202-296-4012 if you have any questions or would like further information about this project.

Sincerely,

Cory L. Richards
Vice President for Public Policy

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Testimony of

Jeannie I. Rosoff

President

The Alan Guttmacher Institute

Senate Committee on Labor and Human Resources

Hearings on

Women's Health Care in the President's Health Care Plan

March 9, 1994

Good morning. My name is Jeannie Rosoff, and I am President of The Alan Guttmacher Institute (AGI), a not-for-profit corporation for reproductive health research, policy analysis and public education. I am pleased to be here today to talk with you about the opportunity presented by health care reform to ensure adequate insurance coverage for women's reproductive health care needs.

Adequate coverage of the full range of reproductive health care services is critical for two reasons: first, because a woman's reproductive years span half of her entire life and, second, because this period is not static but encompasses several stages during which both her reproductive goals and her health care needs change. For example, during the several years in which the typical young woman is sexually active before she wishes to become pregnant, she is likely to need contraceptive services to avoid unwanted pregnancy as well as routine gynecological care that includes screening for sexually transmitted diseases and cancers of the reproductive system, in order to protect her general reproductive health and ensure fertility in the future. During the relatively few of her reproductive years in which the typical woman is pregnant or trying to become pregnant, she should receive a preconception risk assessment and comprehensive maternity care, including prenatal, delivery and postnatal care. A woman confronting an unintended pregnancy may choose to have an abortion, while a woman who has completed her desired family size may seek a contraceptive sterilization. And, a woman unable to conceive may desire infertility services.

To meet women's varied and changing health care needs, then, a reproductive health care package, in order to be truly comprehensive, must include all of these services. While not every woman will need all of them over the course of her life, most women will need many of them at one time or another.

It is important that these reproductive health services be seen as important not only in their own individual right, but also in their critical relationship to one another. For example, family

planning services are related to the achievement of good birth outcomes, while screening and treatment for STDs are important to preventing infertility. Finally, many of these reproductive health services are needed by men as well as women. Ensuring good reproductive health, and good reproductive outcomes, should not be just be a woman's responsibility, a woman's burden.

The AGI Insurance Study

Much is known about the coverage of reproductive health care services through public programs. Unfortunately, much less has been known about the private-sector, employment-related insurance that provides coverage to two-thirds of women of between the ages of 15 and 44[1].

Understanding current patterns of coverage is necessary if we are to transform the existing financing patchwork into an insurance system that truly meets women's health care needs. This is particularly true since any such new system is likely to draw heavily on existing private-sector coverage, making it critical that we know what about current coverage is good and should be retained, and what needs to be improved.

For these reasons, AGI last year undertook the first large-scale study of private insurance coverage of reproductive health care services. In an attempt to obtain a comprehensive picture of the different kinds of coverage American women have, we cast a wide net, surveying the 100 largest commercial insurance companies, all 73 Blue Cross-Blue Shield Plans, all 106 HMOs with 100,000 or more enrollees and a sample of 107 smaller HMOs. The survey -- which was developed in conjunction with a panel of experts in the health care and employee benefits fields -- was completed

[1] Women's Research and Education Institute, Women's Health Insurance Costs and Experience, 1994.

by 58 percent of the commercial companies for whom it was applicable,[2] 53 percent of the applicable Blue Cross-Blue Shield plans and 50 percent of the HMOs surveyed. Altogether, a total of 189 responses are included in the analysis. These results are accurate within 10 percentage points or less, with 95 percent reliability. (A detailed discussion of the methodology is attached.)

This study -- supported by the Robert Wood Johnson Foundation and conducted by AGI Policy and Research Associates Rachel Benson Gold, Daniel Daley and Jennifer Frost -- addresses three issues critical to ensuring that people not only are insured for, but also are able to access, the care they need: whether specific reproductive health care services are covered, whether plans have provisions for patients to obtain confidential care and the ease with which patients can access services in a managed care environment. The full study will be released mid-year.

Because the study is still in progress, we were able for this hearing to analyze data only relating to the first issue -- the extent to which reproductive health services are covered -- and to concentrate only on a few key services out of the 25 we will be considering in the final report. I want to stress, however, that all aspects of the study are critical to a comprehensive understanding of the full range of women's reproductive health insurance needs and the extent to which they are being met.

To address the coverage issue, survey respondents were asked to indicate whether each of the services in question is typically[3]

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[2] Some private insurance companies included in the survey indicated that the survey was not applicable to their business either because they only write either nongroup coverage or policies specifically designed to supplement Medicare coverage.

[3] For purposes of this project, "typical is defined as that which represents the coverage written for most of the lives covered by each policy type or by the individual HMO.

- covered when considered medically necessary or appropriate by the physician ("routinely covered");
- covered only when additional requirements are met; or
- not covered at all.

Recognizing that health insurance comes in many forms in the United States today, we asked the question concerning a wide range of employment-related insurance policies: insured indemnity plans written for groups of under 100 employees, insured indemnity plans written for groups with 100 or more employees and self-insured plans (which together account for 58 percent of insured employees) as well as Preferred Provider Organizations (which account for 20 percent), Point of Service networks (which account for 3 percent) and HMOs (which account for 19 percent)[4].

For purposes of our discussion here today, the numbers I am going to cite will be for insured plans written for large groups, contrasted with HMOs.[5] We have chosen to cite data for large-group plans because, as you can see from the attached tables, there are not many differences among the various types of fee-for-service plans and because large-group plans are the ones that insure most Americans.

Key Findings

We began this project with an understanding of the historic traditions of private-sector health insurance coverage -- generally to provide coverage of surgical services and not to cover preventive care. What we found is that these traditions remain strong today. Considering how much of reproductive health care is preventive in nature, the impact of these traditional patterns on coverage,

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[4] Marianne Miller and Thomas Dial, Employer-sponsored Health Insurance in Private Sector Firms in 1992, Health Insurance Association of America, August 1993.

[5] In general, the data will group commercial companies and Blue Cross-Blue Shield Plans together; when the differences between the two are significant, the data for each are cited.

especially coverage of contraceptive services, is significant and distressing.

- Sterilization and Abortion

Not surprisingly, given traditional practices, surgical reproductive health care services are well covered in typical insurance policies. Sterilization services are routinely covered by at least 85 percent of all types of typical insurance policies. Coverage of abortion follows much the same pattern.

Coverage of abortion services is widespread in all types of health insurance policies. Approximately two-thirds or more of all the types of policies included in this survey -- including 66 percent of large-group fee-for-service policies and 70 percent of HMOs -- routinely cover abortion in their typical plans.

Nonetheless, it is worth pointing out that many plans also place restrictions on the coverage of abortion services. In addition to those plans that routinely cover abortion, nearly one-quarter of large-group plans and one-fifth of HMOs restrict coverage, generally by requiring the provider to certify the presence of a specific medical indication (beyond pregnancy itself) for the procedure. Finally, only 11 percent of large-group plans and 10 percent of HMOs typically do not cover abortion services at all.

- Reversible Contraception

In sharp contrast to the extensive coverage of sterilization and abortion services, but clearly in line with the traditional bias of health insurance against preventive care, coverage of reversible

contraception -- particularly, but not exclusively among indemnity plans -- is insufficient, at best.

None of the five reversible methods included in the survey -- IUDs, Diaphragms, Norplant, DMPA (Depo Provera) injection and oral contraceptives -- is routinely covered by any more than 40 percent of typical plans. Half of the large-group plans typically do not cover any contraceptive method at all (59 percent of typical policies written by commercial companies and 36 percent of those written by Blue Cross-Blue Shield Plans). Only 15 percent cover all five methods (8 percent of commercial companies and 24 percent of Blue Cross-Blue Shields). The extent to which individual contraceptive methods are covered in large-group policies varies significantly in some cases between commercial companies and Blue Cross-Blue Shield Plans; Blue Cross-Blue Shield Plans are significantly more likely to cover IUD insertion, diaphragm fitting and Depo Provera injection than are commercial companies.

Oral contraceptives, the most commonly used reversible method, are routinely covered by only one-third of large-group plans.[6]

The failure of plans to cover oral contraceptives is not the result of an overall failure to cover prescription drugs. While 97 percent of large-group plans typically include coverage of prescription drugs, two-thirds of these plans do not routinely cover oral contraceptives.

Along the same lines, while over 90 percent of large-group plans typically cover medical devices in general, more than 80 percent of these plans do not cover IUDs or diaphragms, and three-fourths do not cover the Norplant device. Only 24 percent of plans routinely cover all three components of Norplant -- the device itself as well as insertion and removal.

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[6] An additional 8 percent of typical plans include restricted coverage of oral contraceptives, generally covering them as a treatment for a specific medical problem such as menstrual irregularities but not for purposes of contraception.

Once again, the tradition of covering surgical care becomes evident. Forty-three percent of large-group plans that cover tubal ligation routinely cover no reversible contraceptive method at all (50 percent of plans written by commercial companies, 36 percent of Blue Cross-Blue Shields).

HMOs provide somewhat more comprehensive coverage of contraception than do fee-for-service plans. Only 7 percent of HMOs provide no contraceptive coverage at all, and 40 percent cover all five methods. Coverage across the various methods ranges widely, however, from 59 percent for Norplant insertion to 86 percent for IUD insertion. Eighty-four percent routinely cover oral contraceptives.

- Counseling and Risk Assessment

Coverage of the support services women need to be able to make informed choices about their reproductive lives is also meager. Only 22 percent of large-group plans routinely cover contraceptive counseling (13 percent of commercial companies and 33 percent of Blue Cross-Blue Shields), while only 43 percent routinely cover preconception risk assessment. In contrast, each of these services is routinely covered by at least 90 percent of HMOs.

Implications

What emerges from these findings -- limited as they are --is a portrait of private insurance coverage that is antiquated in its bias toward surgical care over nonsurgical procedures, curative care over preventive care and medical procedures over counseling and education. These patterns of coverage leave women with little or no coverage for key services they need during their childbearing years. Our emerging national health care reform plan must not model itself on current capricious

patterns of coverage that simply do not address the needs and circumstances of women and couples today.

As we undertake to fashion a new system, one that builds on and improves the current situation, we should keep three things in mind. First, even as we extend to people coverage they do not now have, we must not take away coverage -- such as the coverage of abortion or sterilization -- that is already widespread. Both of these services are critical to the lives of many women and couples. One half of all pregnancies in the United States are unintended, and half of women confronting an unintended pregnancy choose abortion. By the same token, sterilization is the contraceptive method of choice among couples over age 30. Coverage of these important services must be retained.

Second, even as we retain coverage of abortion and sterilization, we must radically expand coverage of contraceptive services. Our study clearly demonstrates that, in order to achieve this end, we will need to be specific. In this sense, the Clinton plan -- despite its apparent intention to provide comprehensive family planning coverage -- falls short. For example, it relies on the general coverage of prescription drugs to assume the coverage of oral contraceptives. What we have learned from our study is that such an assumption is unwarranted: two-thirds of plans that cover prescription drugs now nonetheless do not routinely cover oral contraceptives.

In that same light, reliance on the general term "family planning services," without amplification, to ensure adequate coverage is also insufficient. As with other services spelled out in the bill, family planning services should be clearly defined. There are many models that could be used for this definition, including the one used by the Health Care Financing Administration for

purposes of giving guidance to states claiming federal reimbursement under the Medicaid program.[7] The bottom line is that only this specificity will ensure that coverage intended becomes coverage actually provided.

Finally, let me express our concern over the failure of the Clinton plan to classify family planning as a clinical preventive service. Family planning is a quintessential preventive service; its role in reducing unintended pregnancy, and hence the need for abortion as well as our unacceptably high levels of infant mortality, is undeniable. It is estimated that publicly subsidized family planning services alone prevent 1.2 million unintended pregnancies each year -- 516,000 of which would have ended in abortion and 509,000 in unintended births.[8] The National Commission on Infant Mortality estimated that 10 percent of infant deaths nationwide could be prevented if all women not desiring pregnancy had used contraception.[9] The failure of the Clinton plan to formally designate family planning as the preventive service it is leaves family planning -- alone among preventive services -- subject to deductibles and copayments.

In closing, let me say that we are glad to have been able to accommodate the Committee and

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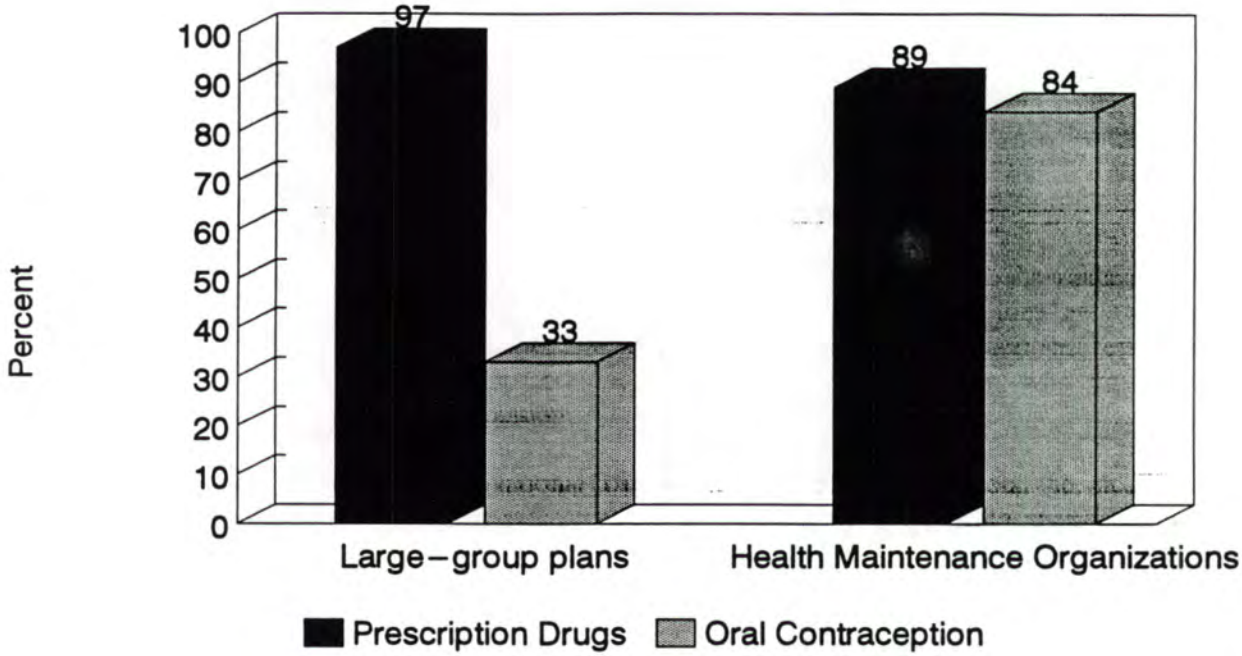
[7] On its quarterly HCFA-64 form, HCFA considers family planning to be "consultation (including counseling and patient education), examination, and treatment, furnished by, or under the supervision of, a physician or prescribed by a physician; laboratory examination; medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception; natural family planning methods; diagnosis and treatment for infertility; and voluntary sterilization and drugs."

[8] J.D. Forrest and S. Singh, "Public-Sector Savings Resulting from Expenditures for Contraceptive Services," Family Planning Perspectives, 22:6, 1990.

[9] National Commission to Prevent Infant Mortality, Troubling Trends: The Health of America's Next Generation, February 1990.

provide you with key findings of our forthcoming study. We will, of course, provide the full report as soon as it is available. In the meantime, I am pleased to respond to any questions you may have.

Percent of large–group plans* and HMOs that routinely cover prescription drugs and oral contraceptives

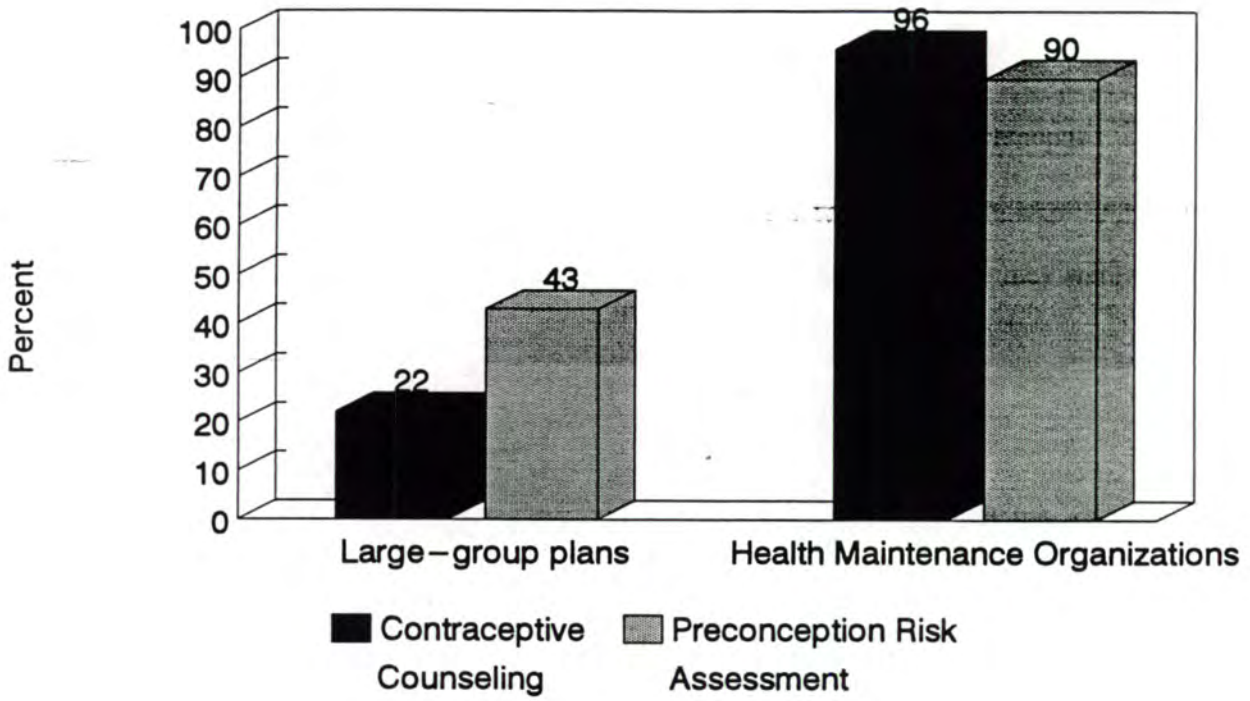


*** Insured indemnity plans written by commercial insurance companies and Blue Cross/Blue Shields for groups of 100 or more employees.**

The Alan Guttmacher Institute

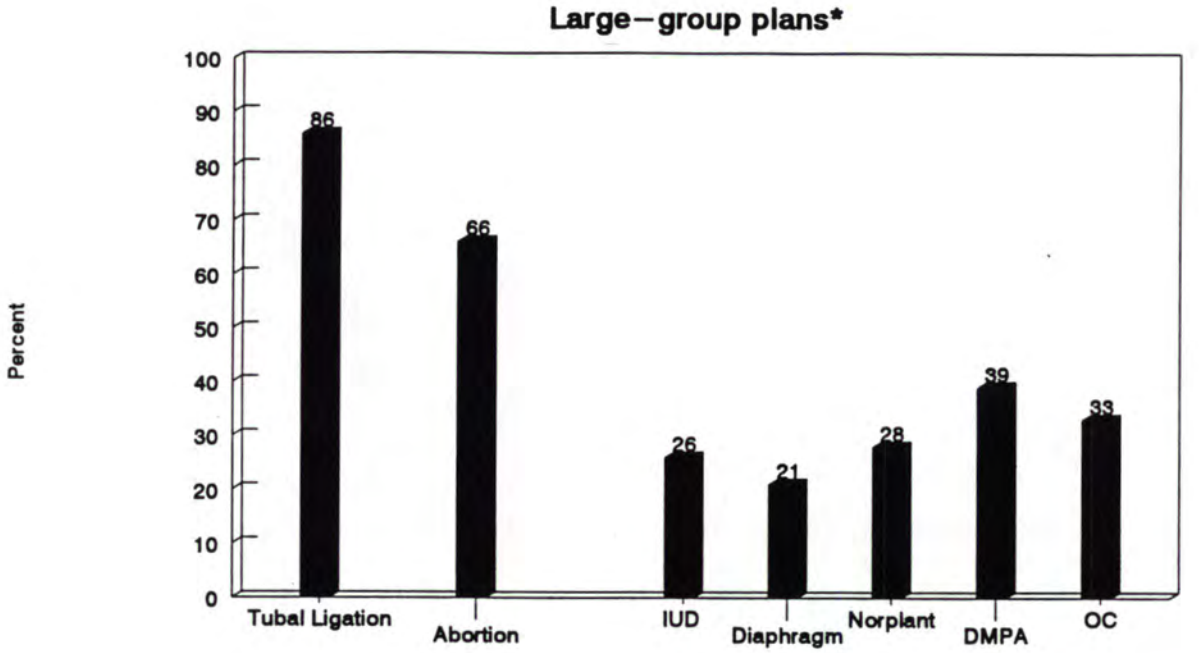
March 1994

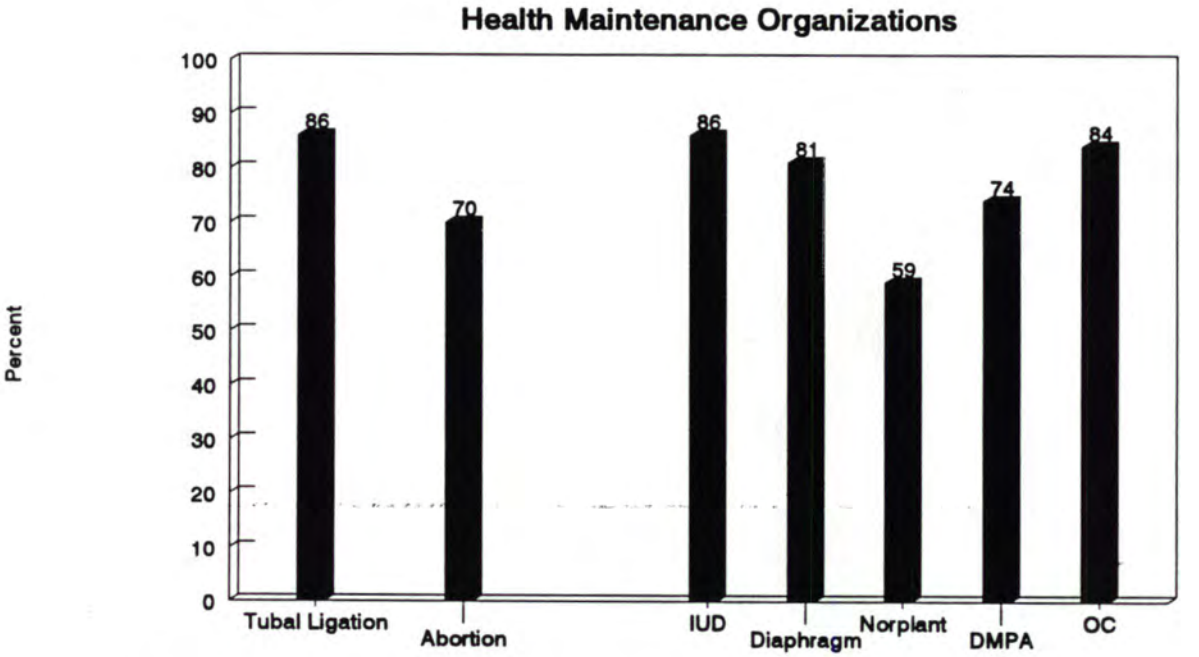
Percent of large–group plans* and HMOs that routinely cover contraceptive counseling and preconception risk assessment



*** Insured indemnity plans written by commercial insurance companies and Blue Cross/Blue Shields for groups of 100 or more employees.**

Percent of typical large–group plans* and HMOs routinely covering sterilization, abortion and reversible contraception





*** Insured indemnity plans written by commercial insurance companies and Blue Cross/Blue Shields for groups of 100 or more employees.**

Percent of typical plans in which specific service is routinely covered, by type of plan

Service	Conventional Indemnity Plans, by size of group			Preferred Provider Organizations *	Health Maintenance Organizations *
	Insured Plans < 100 Employees	Insured Plans >100 Employees	Self-insured Plans *		
Prescription drugs	97	97	98	99	89
Medical devices	91	92	98	94	83
Contraceptive Sterilization					
Laparoscopic tubal ligation	86	86	86	86	86
Vasectomy	85	85	86	86	88
Abortion					
Dilation and curettage/suction aspiration	64	66	68	67	70
Dilation and evacuation	66	69	68	67	70
Reversible Contraception					
IUD insertion	23	26	25	25	86
Diaphragm/cervical cap fitting	19	21	21	23	81
Norplant insertion	26	28	30	29	59
Norplant removal	30	32	36	33	58
DMPA (Depo Provera) injection	34	39	32	35	74
Diaphragm device	15	15	16	17	52
IUD device	16	18	20	21	47
Norplant device	23	24	27	27	44
Oral contraceptives	32	33	38	41	84
Counseling and Risk Assessment					
Contraceptive counseling	22	22	16	24	96
Preconception risk assessment	40	43	38	42	90

* Includes plans of all sizes.

Percent of typical plans in which specific service is covered subject to additional restrictions, by type of plan

Service	Conventional Indemnity Plans, by size of group			Preferred Provider Organizations *	Health Maintenance Organizations *
	Insured Plans <100 Employees	Insured Plans >100 Employees	Self- Insured Plans *		
Prescription drugs	NA	NA	NA	NA	NA
Medical devices	NA	NA	NA	NA	NA
Contraceptive Sterilization					
Laparoscopic tubal ligation	4	4	5	4	8
Vasectomy	4	4	5	4	6
Abortion					
Dilation and curettage/suction aspiration	21	23	18	20	20
Dilation and evacuation	18	20	18	19	20
Reversible Contraception					
IUD insertion	0	0	0	0	0
Diaphragm/cervical cap fitting	1	1	0	0	0
Norplant insertion	0	0	0	0	3
Norplant removal	6	4	4	4	7
DMPA (Depo Provera) injection	4	4	5	7	6
Diaphragm device	0	0	0	0	0
IUD device	0	0	0	0	0
Norplant device	0	0	0	0	3
Oral contraceptives	8	8	11	7	2
Counseling and Risk Assessment					
Contraceptive Counseling	1	0	0	0	0
Preconception risk assessment	3	4	2	4	3

* Includes plans of all sizes.

Percent of typical plans in which service is not covered, by type of plan

Services	Conventional Indemnity Plans, by size of group			Preferred Provider Organizations *	Health Maintenance Organizations *
	Insured Plans <100 Employees	Insured Plans >100 Employees	Self-insured Plans *		
Prescription Drugs	3	3	2	1	11
Medical Devices	9	8	2	6	17
Contraceptive Sterilization					
Laparoscopic tubal ligation	10	10	9	10	7
Vasectomy	11	11	9	10	7
Abortion					
Dilation and curettage/suction aspiration	15	11	14	13	10
Dilation and evacuation	16	11	14	14	10
Reversible Contraception					
IUD insertion	77	74	75	75	14
Diaphragm/cervical cap fitting	80	78	79	77	19
Norplant insertion	74	72	70	71	39
Norplant removal	64	64	61	62	35
DMPA (Depo Provera) injection	62	57	63	58	20
Diaphragm device	85	85	84	83	48
IUD device	84	82	80	79	53
Norplant device	77	76	73	73	54
Oral contraceptives	60	58	52	52	14
Counseling and Risk Assessment					
Contraceptive counseling	77	78	84	76	4
Preconception risk assessment	57	53	60	54	7

* Includes plans of all sizes.

METHODOLOGY

The 1993 AGI survey of health insurers had three components: commercial insurance companies, Blue Cross-Blue Shield Plans and Health Maintenance Organizations. The surveys for the commercial companies and Blue Cross-Blue Shield Plans were identical, while the survey for the HMOs included identical questions concerning the coverage of specific reproductive health care services as well as other questions specifically relevant to managed care plans. Each of these survey instruments was developed in conjunction with a panel of experts in the health care and employee benefits fields.

- Commercial insurance companies

The commercial insurance survey was sent to the 100 largest commercial insurance companies in the United States based on the ranking of insurance companies -- according to their net accident and health premiums written -- included in National Underwriters Profiles: 1993 Health Insurers. The name and address of the Chief Executive Officer (CEO) of each insurance company was obtained from Best's Insurance Reports: Life/Health Edition.

Based on data included in the National Underwriters Profiles on the total net accident and health premiums written for all insurers, we calculated the share of the total health insurance market that was covered by the sample of the 100 largest commercial insurers. Together, these insurers surveyed accounted for 97 percent of the total health insurance market.

The 12-page survey instrument was mailed to the CEO of each insurer on October 19, 1993. A second mailing was sent on November 12, and telephone follow-up both to obtain additional responses and clarify issues arising from survey responses continued through December 1993.

Insurers were given the following instructions about completing the questionnaire: "Please answer the questions pertaining to your policy/contract written for groups to cover employees and their dependents in 1993. These questions do not apply to coverage written for persons not part of a group or to coverage supplementing Medicare benefits." For purposes of the survey, the term "typical" was defined as "that which represents the coverage written for most of the lives covered under each policy type." The survey was divided into five parts, each on one type of policy/contract, essentially repeating a single set of questions for each type of policy/contract:

- insured indemnity health insurance policies/contracts for groups with fewer than 100 employees (with a special sub-section concerning policies for groups with 15 or fewer employees);
- insured indemnity health insurance policies/contracts written for groups with 100 or more employees;
- self-insured indemnity policies/contracts administered under Administrative Services Only agreements;
- Preferred Provider Organizations (insured and self-insured); and

- Point of Service networks (insured and self-insured).

Of the 100 surveys mailed, 45 insurers participated in the study, 23 insurers indicated that the survey was not applicable because they did not provide group health insurance coverage and 32 did not participate in the project. (The "not-applicable" firms generally did not write group health insurance policies, with most offering only either non-group coverage or Medicare supplement policies.) The most frequently given reason among nonrespondents were the length of the questionnaire and the level of detail required. As a result, 58 percent of the firms for whom the survey is applicable responded. These responding insurers account for 68 percent of the applicable health insurance market, calculated based on net premiums written. Eight of the 10 largest commercial insurance companies responded.

Not all participating insurers wrote all five types of coverage about which they were questioned in the survey. All data presented concern only those insurers that write each type of plan and responded concerning the specific service.

- Blue Cross-Blue Shield Plans

The survey was sent to all 73 Blue Cross-Blue Shield Plans in the United States, based on the listing of all such Plans included in the Blue Cross-Blue Shield Association Winter 1993 Directory. The survey was sent to the CEO of each Plan on October 19, with a second mailing sent November 8. Telephone follow-up continued through December 1993.

The survey instrument was identical to that mailed to commercial insurance companies.

A total of 38 Plans responded to the survey. Thirty-four Plans did not participate, and one Plan indicated that the survey was not applicable since it is an association office that does not actually write insurance coverage. As a result, the response rate is 53 percent of the 72 applicable plans.

- Health Maintenance Organizations

The sample of HMOs was constructed using the 1993 National Directory of HMOs published by the Group Health Association of America. This directory lists the 546 HMOs in operation as of December 1992. Using the data included in the directory, a sample was constructed to include:

- All 106 HMOs with 100,000 or more enrollees. (These 106 HMOs represent approximately 20 percent of all HMOs and account for 68 percent of all HMO enrollees nationwide.)

- A sample of 107 of the smaller HMOs. To obtain this sample, the remaining 440 smaller HMOs were stratified according to enrollment size (HMOs with less than 20,000 enrollees and HMOs with 20,000 to 99,000 enrollees) and region of the country (Northeast, Central, South and West),. We included 23 percent of these 440 HMOs (107 HMOs) by selecting every fourth HMO within regions and enrollment size categories.

Overall, the 213 HMOs included in the sample account for 32.4 million enrollees, 76 percent of all HMO enrollees in 1992.

The HMO survey was mailed on October 25, with a second mailing November 12.

Overall, 106 of the 213 HMOs sampled responded with completed surveys, a response rate of 50 percent. Of HMOs with 100,000 or more enrollees (106 sampled), a total of 61 responded, a response rate of 58 percent. Of HMOs with less than 100,000 enrollees (107 sampled), a total of 45 responded, a response rate of 42 percent.

The HMOs responding to the survey include 17.6 million enrollees, 56 percent of all enrollees covered by the HMOs included in the sample, and 43 percent of all HMO enrollees in 1992.

- Questions asked

Each of the five major sections of the 12-page survey sent to private health insurance companies and Blue Cross-Blue Shield plans contained questions concerning the coverage typically available for a list of 25 specific reproductive health care services, each of which was identified by either CPT-4 codes or codes from the HCFA Common Procedure Coding System, as well as provisions for confidentiality for both spouses and nonspouse dependents. Additional questions concerned the details of the availability of services in Point of Service networks and the coverage of specific services for dependents -- including spouses and nonspouse dependents -- of the insured employee. The sub-section concerning groups with fewer than 15 employees asked about a shorter list of medical services than was include din the full sections.

For each medical service included in the survey, insurers (private health insurance companies and Blue Cross-Blue Shield Plans) and HMOs were asked to indicate whether, in the typical employment-related policy of each of the types included in the survey, it is

> "(1) not covered at all;
> (2) covered when considered medically necessary or appropriate by the physician; or
> (3) covered **only** when additional requirements (i.e., additional written report from the physician providing specific medical justification, prior authorization, etc.) are met?"

Respondents were asked to check one of these three categories. A respondent indicating that a service was covered subject to additional requirements was asked to specify these additional requirements. In general, the additional requirements reported by the insurers and HMOs fell into two categories. The first was that a provider specify the presence of a specified medical indication in order for coverage to be obtained. The second major category of additional requirements was that prior authorization be obtained before a service could be covered.

The 12-page HMO survey instrument continued instructions similar to those in the two other survey instruments concerning benefits provided in the typical plan written to cover employees and their dependents. An identical definition of "typical" was used. The survey defined sub-contracted services"

to be in-plan services "delivered by providers not members of the HMO network, but under contract."

The HMO survey also asked identical questions about the coverage of the list of 25 specific reproductive health care services. In addition, the HMO survey asked questions about coverage of out-of-plan services and services to Medicaid recipients.

- Statistical significance

For all three components of this study – commercial insurance companies, Blue Cross-Blue Shield Plans and Health Maintenance Organizations – we used a purposive sampling methodology so as to ensure that those companies that provide coverage to the largest number of enrollees were included. The results are expressed as percentages of "plans" (not individuals covered) providing coverage for specific reproductive health services.

Based on a sample of 100 respondent companies, these percentages are accurate within approximately 10 percentage points or less with 95 percent reliability. For example, the 95 percent confidence interval around a percentage value of 50 percent is approximately plus or minus 10 percentage points. (The interval will be slightly narrower for HMOs and slightly wider for private companies and Blue Cross-Blue Shield Plans combined because of differences in the number of respondent plans). The 95 percent confidence interval around percentage values that are above or below 50 percent become progressively smaller, with the interval around a value of 90 percent for a sample of 100 companies being plus or minus six percentage points.

Tabulations for the coverage of specific services were done combining the information provided by private companies and Blue Cross-Blue Shield Plans. We also did separate tabulations for each, testing whether or not the observed differences were significant. To do this, we computed chi-squared values for the coverage of each service by private companies compared with Blue Cross-Blue Shield Plans, noting cases where the chi-squared values were significant at the .05 level.