Women's Domestic Issues

preserving status quo / plans + physicians

While this approach is the clearest way to cover abortion, anti-abortion interest groups will oppose it.

2. Address Coverage of Abortion Indirectly

National health reform legislation would include "~~family~~ planning ~~services and~~ pregnancy-related care" in the benefit package but would remain silent on elective abortions. The legislation would require that all services in the benefit package be "medically necessary or appropriate." However, statutes and judicial opinions do not clearly define "medically necessary" and "medically appropriate" in the abortion context.

Legal authority suggests, but does not definitively state, that the term "medically necessary" does not cover elective abortion. In Beal v. Doe, 432 U.S. 438 (1977), the Supreme Court upheld a state regulation requiring physicians to certify that an abortion is "medically necessary" in order to receive state Medicaid funding. In permitting Pennsylvania to deny funding for "elective" -- or non-therapeutic -- abortions, the Supreme Court implied that the term "medically necessary" does not cover elective abortions.

Furthermore, there is no uniformity or consistency in the use of the term "medically necessary" under state Medicaid policies. Some states cover all or most abortions under the term "medically necessary." For example, Massachusetts defines the phrase broadly to include any abortion that "according to the medical judgment of a licensed physician, is necessary in light of all factors affecting the women's health." Other states interpret the phrase "medically necessary" very narrowly. Arizona defines "medically necessary" abortions as only those necessary to save the life of the woman.

Because legal authority suggests that elective abortions are not "medically necessary," abortion is more likely to be covered if the legislation provides that services must be "medically necessary or appropriate." The meaning of medically appropriate is even less clear, however, although it is probably broader than the term "medically necessary" and seems to leave discretion with physicians.

Including the term "medically necessary or appropriate" may have the following effects:

- A physician, provider or plan might conclude that no elective abortion is "medically necessary or appropriate" and therefore refuse to perform or even inform patients about abortion services. It is conceivable that, if federal legislation contains imprecise terms, all plans in an alliance might refuse to provide elective

abortion services. It is more likely that at least one plan in an alliance would exclude abortion. A plan that determined that abortion was not covered by the terms "medically necessary or appropriate family planning services and pregnancy related services" would argue that the plan has no obligation to find a provider willing to provide an abortion.

- The National Board, charged with defining the benefit package, has the power to determine whether abortion is covered.

- Ultimately, courts will decide whether elective abortions are "medically necessary or appropriate." Federal courts may interpret these terms differently, leading to different coverage in different areas of the country. Furthermore, ambiguity in statute and unclear Congressional intent often leads to confusion in federal court interpretation.

Conscience clause for institutions + providers not overriding state law

3. Offer Supplemental Insurance

Under this option, individuals could purchase supplemental insurance for abortion coverage. Supplemental insurance could be available if abortion were excluded from the benefit package; it could also be purchased if health reform legislation leaves open the question of whether "medically necessary or appropriate pregnancy-related services" covers abortions.

By giving each individual the opportunity to purchase additional coverage, supplemental insurance is consistent with a woman's right to choose.

However:

- Women who now have abortion coverage through private plans would pay more for the status quo.

- Low-income women might be unable to afford either the supplemental package or an abortion itself. This though would simply maintain the current situation; many low-income women are currently unable to afford abortions since the Hyde amendment prohibits use of federal funds for abortions except in narrowly circumscribed cases.

4. Create a Voluntary Fund

At the time of enrollment in a plan, enrollees could elect to contribute to a fund used to pay the costs of abortion.

TO: Files
FROM: Jennifer Klein
DATE: June 7, 1993
RE: Treatment of Abortion

This memo describes current coverage of abortion services and outlines options for addressing abortion in national health reform legislation.

Current Coverage of Abortion

Currently, there is no uniform treatment of abortion in private, state or federal health plans.

Private Plans

- According to the Alan Guttmacher Institute, there is little reliable information on abortion (or even family planning) coverage practices by private insurers or health plans.

- Most private insurance plans do not specifically cover abortion. Rather they implicitly cover abortion within a broader category such as "pregnancy and all related conditions" or "interrupted pregnancy and all services necessary to childbirth, including pre-natal and post-partum, and any complication of pregnancy." Some insurance plans explicitly identify abortion as a covered benefit.

- The Pregnancy Discrimination Act of 1985 allows employers to exclude abortion services in health insurance policies, except if the woman's life is endangered.

States

- Ten states (CO, ID, IL, KY, MA, MO, NE, ND, PA, RI) require the exclusion of at least some abortions from private health insurance coverage. Four of these states (ID, KY, MO, ND) prohibit coverage by private insurance unless the employee pays for a separate rider.

- Some states restrict abortion services by requiring that minors receive parental notification or consent or by imposing 24-hour waiting periods on all women. The options for abortion described in this memo do not preempt such state law restrictions.

- All states, with federal matching funds, pay for abortions for Medicaid recipients in cases of life endangerment. States assume the full cost of abortions

for Medicaid recipients in the following cases:

- Rape or incest (20 states)
- Fetal deformity (15 states)
- Elective abortions (12 states)

Federal

- Current law prohibits use of federal funds for abortions except in cases of life endangerment.
- Federal funding may not be used for abortions for beneficiaries of the Federal Employee Health Benefit Plan, federal prisoners, Peace Corps volunteers, and Native Americans who receive care through the Indian Health Service.

Options for Abortion Under Health Reform

It is impossible to legislate the status quo. First, since health reform legislation will specify a nationally guaranteed benefit package, any treatment of abortion will be a change from the current environment in which private and public plans determine whether particular services are covered. In addition, it is impossible to identify a status quo; some plans cover abortion while many do not.

Pro-choice advocates support including abortion in the benefit package because it will preserve the status quo for women who currently receive coverage under private insurance plans. Opponents counter that including abortion in the benefit package sanctions abortion and requires all individuals, regardless of their viewpoint, to pay for abortions. Advocates on both sides will demand that the issue be addressed.

1. Cover Abortion Services Explicitly

National health reform legislation would explicitly include elective abortion in the benefit package. Health care providers could refuse to perform abortions, but plans would be required to offer at least one provider to perform abortions or contract out-of-plan for abortion services.

If elective abortions were explicitly covered, abortion would be the only elective service in the benefit package. All other benefits would be available only if "medically necessary or appropriate."

Since current law prohibits using federal funds to pay for abortion, voluntary contributions would be pooled to create a "non-federal" fund. When a woman received an abortion, the plan would obtain reimbursement for the procedure from this fund.

Simple calculation indicates that the fund will need between $320 and $800 million each year to fund all elective abortions. There are approximately 1.6 million abortions each year. The cost of abortion services varies significantly depending, for example, on method and geographic region, but ranges from approximately $200 to $500. It is, of course, difficult to estimate the amount that would be captured by a voluntary fund.

By permitting individuals to act on their own values, this approach would avoid some of the controversy provoked by legislating abortion coverage.

Optain - Pregnancy - R

REPRODUCTIVE HEALTH SERVICES

DESIGNING A REPRODUCTIVE HEALTH BENEFIT

INTRODUCTION

In looking to design a new benefit package it is critical that the inclusion of women be considered from the beginning. It is also important that the coverage of services for reproductive health, not be based solely on current services provided through employer-based plans. Historically, health insurance plans in the United States emerged as an employer-provided benefit for its employees, the majority of whom were male. Coverage for women and children, if provided at all, was added on as dependent coverage. Frequently, routine care for women (and children), including maternity care, was outside the scope of the basic benefit coverage, and provided only at additional cost to the employee.

With the entrance of increasing numbers of women into the workforce over the last 20 years, employer-provided insurance has been extended to cover more routine gynecological care for women. Watershed legislation -- the Pregnancy Discrimination Act --P.L. 95-555 which was enacted in 1978, amended the Civil Rights Act of 1964, prohibiting employers from discriminating against pregnancy-related care (not including abortion) in the health insurance plans they offer. The PDA, however, does not require companies to offer insurance. Nor does it require coverage of dependents. Moreover, this law does not apply to companies with fewer than 15 employees and does not guarantee comprehensive preventive and routine care for non-pregnancy related conditions.

Today, over one-quarter of women of childbearing age (approximately 14.6 million women) have no insurance (public or private) to cover maternity services (i.e. prenatal, labor and delivery and post-partum care.) This includes 9.5 million women who have no insurance at all and 5 million women who have private insurance that does not cover maternity care.

Even when maternity-related benefits are provided, pre-existing exclusion clauses often limit coverage for new participants, including women who are pregnant at the time. As a consequence, women may be forced to wait up to ten months before such coverage begins.

During recent years there has been growing recognition that the study of diseases and conditions unique to or more prevalent in women has been overlooked and resulted in treatment and health services that are inadequate. In addition, the lack of coverage for a broad array of prevention and health promotion services has led to limited access for men and women to reproductive health care. Women's health care needs must be fully and equitably addressed in a national health care benefits package.

One critically important way to redress the gap in women's health care is to focus on the prevention of disease, and the maintenance of health and well-being. Prevention services,

family planning services and post reproductive health services must be the foundation upon which a national health care system is built -- not an afterthought.

HISTORIC OPPORTUNITY FOR A REPRODUCTIVE HEALTH BENEFITS

The design of a new benefit package offers a unique and historic opportunity to turn around the way reproductive health care has been delivered in this country. Today, women and men, find a fragmented system of services, inconsistent coverage from plan to plan, and state to state for routine preventive and reproductive health care. We have the opportunity to create a comprehensive package of reproductive health benefits for men and women throughout their life span.

A reproductive health package would include:

Family Planning Services

- contraceptive services and supplies
- voluntary sterilization
- basic infertility services
- screening for sexually transmitted diseases
- screening for cervical, breast, prostate cancers
- preconception risk assessment and care;
- related diagnostic, education and counseling

Pregnancy-related Care

- maternity care, including prenatal, delivery and postnatal gynecology;
- termination of pregnancy/abortion services

Post Reproductive Care

- screening for cervical, breast, prostate cancers
- osteoporosis risk assessment, counseling and education

CURRENT COVERAGE FOR SPECIFIC REPRODUCTIVE SERVICES

1. Contraceptive Services and Supplies

No comprehensive data on private insurance coverage of contraceptive services exist. Fewer than one health insurance plan in five appears to cover routine family planning visits to a physician's office if those services are consider to be adult periodic examinations for preventive care. While most insurance plan participants appear to have coverage for prescription drugs (which would include oral contraceptives), it is not clear whether contraceptive drugs or devices are covered or are excluded as preventive care. (AGI)

New contraceptive methods, such as Norplant and Depo-Provera, and intravaginal devices which will soon come to market, are difficult to classify as "pure" drug or device, and require varying levels of provider effort.

Under Medicaid, family planning is an explicitly mandated service, but the specific services covered my vary from state to state. Family planning services are the only medical services eligible under Medicaid to receive a 90 percent federal match. All other services are reimbursed between 50 and 80 percent.

State funds are the second largest source of funds spent on contraceptive services. At least 44 states and the District of Columbia spent some of their own funds for this purpose in 1990.

Other Federal Programs. Title X of the Public Health Service Act is the only federal program devoted solely to providing family planning services. Congress appropriated $173 million for Title X for fiscal year 93. Two other federal block grants, Maternal and Child Health and the Social Services Block Grant provide additional family planing funds.

2. Sterilization

Private insurance: No comprehensive data exists for private insurance coverage. One study from 1976 found that 34 of 37 commercial insurance companies covered female sterilization, and 27 of the 37 covered vasectomy.

Under Medicaid, sterilization is covered in all states and is usually reimbursed at the 90% federal matching rate as a family planning service. Since 1979, federal regulations have prohibited reimbursement for sterilization of anyone under age 21 or mentally incompetent. Informed consent and a 30 day waiting period is also required.

3. Infertility services

Private insurance: Coverage for diagnosis and treatment of infertility is inconsistent. Ten states have enacted laws requiring infertility insurance coverage. (AR,CA, CT,HI,IL,MD,MA,NY,RI,TX.) The majority of statutes place limits on coverage either by limiting the dollar amount or by limiting services. The Health Insurance Association of America estimates that 40% of people privately insured have coverage for some services related to in vitro fertilization.

The National Center for Health Statistics reported in 1990 that infertility affects 2.3 million married couples, or 4.9 million people in the U.S. This figure represents 8 percent of the population, or 1 in 12 couples. While 2.3 million American women today are affected infertility, only have of these women pursued treatment in 1988. Fewer than 2 percent of those seeking treatment undergo the assisted reproductive technologies (in vitro (IVF), gamete intrafallopian transfer (GIFT)).

The majority of infertile couples require relatively low-cost conventional methods of treatment. Only one tenth of one percent (o.1%) of the total United States health care budget is spent on infertility services. The assisted reproductive technologies account for roughly three hundredths of a percent (0.03%) of the cost of health care in this country.

Under Medicaid, infertility is considered a family planning service and therefore may be offered by states. No state paid for in vitro fertilization as of 1987, although some states have indicated that they would cover these services if a claim were filed.

Other Public Programs: Title X grantees are required to offer "Level 1" infertility services which include: infertility interview, education, examination, appropriate lab tests, counseling, and referral.

4. Screening for sexually transmitted diseases

Private insurance: Private insurance is likely to cover the diagnosis and treatment of STD's and their complications. Women, however, often have no symptoms for STD's such as chlamydia and gonorrhea which would lead to appropriate diagnosis and treatment. No data exists on coverage STD screening. Routine screening for women at high risk is necessary to prevent more serious diseases such as pelvic inflammatory disease, leading to infertility.

Medicaid: Diagnosis and treatment of STD's are covered under Medicaid.

Other Public Programs: The STD program, operated by the Centers for Disease Control, provides grants to state and local health departments for STD prevention and control. The recently passed Infertility Prevention Act provides screening for STD's at family planning clinics and other clinics where women go for health care. Both of these programs, however, have limited funds.

5. Screening for reproductive cancers (cervical, breast, prostate)

Private insurance: Private insurance plans generally do cover mammograms, with most states (42) requiring that private insurers offer coverage for mammograms. There is not enough data on pap smears and only 10 states mandate coverage of pap smears. However, many believe that pap smears are covered if routine examinations are covered. No data is available on coverage of prostate cancer screening (PSA test).

Medicaid: Medicaid generally covers mammograms and pap smears, however many states have very limited reimbursement and have age and frequency limits.

Other Public Programs Medicare covers the cost for mammography screening for women over the age of 65 every two years and every year for women over the age of 50 who are disabled and Medicare eligible. Medicare limits the cost of mammography screening to $55.

In 1990, Congress enacted into law the Breast and Cervical Cancer Mortality Prevention Act to provide mammography and pap screens to low-income women. Currently, 15 states have established programs and receive funding through the Centers for Disease Control. Congress appropriated $73 million for fiscal year 1993. Full funding of this program is estimated to be $800 million. The program includes education, outreach and other services to ensure that hard to reach populations get screened.

6. Maternity care, including prenatal, delivery and postnatal gynecology;

Private insurance: Most private insurance policies cover maternity care, although there are many women of reproductive age who do not have coverage for maternity care (see above). Many of the gaps are due to loopholes in the Pregnancy Discrimination Act. The PDA allows for exclusion for pregnancy of a non-spouse dependant, such as a pregnant daughter. Only 25% of private policies provide coverage for both a dependant teenager and her newborn infant.

Medicaid: Pregnant women are eligible for Medicaid coverage as long as they meet certain income criteria, which are not as stringent as requirements for welfare eligibility. States are required to cover pregnant women with incomes of up to 133% of poverty.

Pregnant women with incomes of up to 185% of poverty may be covered at the state's discretion.

Other Public programs: The Maternal and Child Health Block grant, community and migrant health centers, and the Indian Health Service provide health benefits to low income pregnant women. The Women Infants and Children (WIC) program provides food, nutrition information and health care referrals to eligible pregnant women and new mothers.

7. Abortion services

Private Insurance: No recent comprehensive data on provision of abortion services by private insurers is known. The Pregnancy Discrimination Act provided that employers may exclude abortion services in their health insurance policies offered to employees except in the case of life endangerment. The PDA does not preclude employers from providing an abortion benefit if they choose to do so.

Ten states (CO,ID,IL,KY,MA,MO,NE,ND,PA,RI) have laws that require the exclusion of abortion from at least some health insurance coverage. Four of these states (ID,KY,MO,ND) prohibit coverage by private insurance unless the employee pays for a separate rider.

The insurance plans offered to Federal employees cover abortions only in cases of life endangerment.

According to the Commission for Professional Hospital Activities, in 1985, 62% of all abortions performed in hospitals were to be covered by private insurance. Data on the percentage of abortions performed at abortion clinics that were paid by private insurance is not available. Last year there were approximately 1.6 million abortions.

Private insurers and HMO's that cover abortions generally do so because they consider abortion a medically necessary treatment for the condition of pregnancy. Medical necessity, in this instance, is determined at the moment of pregnancy, since pregnancy requires medical services -- whether for delivery and childbirth or for termination.

Coverage for abortion services is generally not identified in private insurance plans. Such services are presumed to be provided, however, unless the plan specifically excludes such coverage. Reliance on a medical necessity standard, in the absence of a clearly defined benefit, raises serious concerns about the protection and continuation of such services in the future [see discussion of medically necessary below].

Public Funding: In 1977, Congress adopted the first of a series of restrictions on federal funding for abortion, popularly referred to as the "Hyde amendment". The Hyde amendment was attached to the FY 1977 Departments of Labor and Health, Education and Welfare Appropriation Act. As adopted it provides that "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 1981, the Hyde amendment was extended to embrace the Departments of Treasury and Postal Service Appropriations Act, prohibiting the use of Federal Employee Health Benefits to pay for abortions. This provision has been reenacted every year since.

Prior to the enactment of the Hyde amendment in 1977, medically necessary abortions were covered under Medicaid in most states. Since then, federal Medicaid funding essentially has been non-existent and since 1981, federal funds have been available only in cases of life endangerment. In addition federal funding of abortion is restricted for women who are dependant for the federal government for the health care: Peace Corps volunteers, women in federal prisons, and Native American women who use the Indian Health Service.

Thirty states and the District of Columbia do not provide Medicaid funding using state or local funds for abortions except in the case of life endangerment. Congress sought to restore the right for D.C. to use local funds for abortions in 1989, but the measure was vetoed twice by President Bush.

Eight states will fund abortions in only very limited additional circumstances (e.g.rape or incest).

Twelve states fund Medicaid abortions for low income women using state funds. These are AK,CA,CT,HI,MA,NJ,NY,NC,OR,VT,WA,WV. Some of these states fund abortions because they are under a state court order to do so.

Comparison of selected plans:

1) Private Plans: (C)

BC/BS: of five plans examined, three make no reference to abortion services and two specify that they only provide abortions under limited circumstances.

Other Indemnity Plans/PPO's/HMO's (Aetna, Guardian, PennState Faculty, Lincoln, Kaiser): of eight plans examined, six make no reference to abortion, one specifically covers elective abortions (PennState), and one specifically provides abortions under limited circumstances (Kaiser).

2) State and Local Plans:

Hawaii: Hawaii covers abortion under the section of basic maternity benefits in the provision for "Pregnancy,Childbirth, and Related Medical Conditions." Coverage is provided "for pregnancy, childbirth or other termination of pregnancy, and related medical conditions."

Oregon: the Oregon Health Plan, which was denied a Medicaid waiver by the Dept. of Health and Human Services, would cover abortion services.

Minnesota: abortion services would be covered only in the case of life endangerment.

3) International Plans:

In many countries, abortion services are organized and financed in the same way as other medical services. In a 1986 paper, the Alan Guttmacher Institute reviewed international abortion services. Many Western European countries provide full funding of abortions although some require a copayment (Sweden, Canada, France). In England an Wales, abortions are provided through the National Health Service, but nearly half of the women seeking abortions go to private physicians. Reasons for seeking private care include avoiding bureaucratic delays, limitations by some NHS hospitals, and lack of access to outpatient clinics. (see attached) (A)

USE OF THE TERM MEDICALLY NECESSARY

It is uncertain at best whether needed reproductive health services, including abortion, would be covered under a "medically necessary" standard. The use of the term "medical necessity" has often been defined too narrowly to provide for the coverage of family planning and abortion services. There is also some concern that the continued use of this term, limits the coverage of prevention and health promotion services generally.

The term "medically necessary" is derived from Medicare and is used to exclude from coverage "items and services...which are not reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member." 42 U.S.C. #1395y(a).

It is unclear how such a standard would apply to abortion or to other forms of reproductive health care. However, it is likely that many abortions would not be covered under this narrow injury and illness standard established to meet the health needs of senior citizens.

Congressional proposals and the use of medically necessary. Almost all of the health care reform bills introduced in the 102nd Congress, however, generally limited coverage for services and supplies to those considered "medically necessary." The majority of these proposals referred to the limitation imposed under Medicare. (S. 1227, the Mitchell/Kennedy bill, did not define "medically necessary.")

Supreme Court has recognized two categories of abortion. The Supreme Court has recognized two separate categories of abortion: "medically necessary" or therapeutic abortions, and elective, or non-therapeutic abortions.

In 1977, in Beal v. Doe, the Supreme Court upheld a Pennsylvania regulation requiring doctors to certify that an abortion is "medically necessary" --under a narrow definition of the term -- in order to receive Medicaid reimbursement. A divided Court permitted the state to deny funding for "elective" - or non-therapeutic abortions. The definition of medically necessary adopted by the state of Pennsylvania excluded many abortions. Only those abortions were covered in which there was documented evidence that the pregnancy threatened the health of the mother, that the fetus might be born with an "an incapacitating physical deformity" or "mental deficiency," or that the pregnancy resulted from rape or incest and might threaten the woman's physical or mental health. (B)

Such a distinction between "medically necessary" and "elective" abortions is flawed. It allows for assessment of the "medical necessity" of each abortion. In Justice Brennon's dissent, he argued that,

> "Pregnancy is unquestionably a condition requiring medical attention." He reached "the conclusion that elective abortions constitute medically necessary treatment for the condition of pregnancy".

Private health insurance plans have tended to view abortion as a condition of pregnancy in order to provide for the coverage of abortion services. Abortions are provided under this rationale rather than any explicit policy making abortion available in most plans. One notable exception is the Penn State Faculty/Staff benefits that clearly provides abortion services under "maternity expenses, stating that elective abortion coverage is limited to $320 for hospital coverage and $120 for physician services.

Unless federal policy makers make clear the definition of "medical necessity" for use by a national health care system, the distinctions and restrictions allowed in Beal case could be applied to exclude coverage of abortion.

If the term "medical necessity" is used to define the scope of benefits generally, it must be clearly stated that such a definition includes coverage for abortion services as a treatment for the condition of pregnancy, as well as for other reproductive health services and preventive services, such as family planning services.

REFERENCES

Abortion: Legislative Control, Congressional Research Service Brief, by Thomas P. Carr, September 29, 1992.

A Comparative Survey of the Laws on Abortion of Selected Countries, Theresa Papademetriou. European Law Division, Law Library of Congress, April, 1990.

Coverage of Reproductive Health Care Services Under Private Health Insurance and Medicaid. The Alan Guttmacher Institute, January 1992

Who Decides: A State by State Review of Abortion Rights. The NARAL Foundation, January 1993

Coverage of Abortion and Reproductive Health in Health Care Reform. Memo by the National Women's Law Center, February, 1993

Major State Health Care Reform Measures, Memo by the Alan Guttmacher Institute. November 12, 1992.

Infertility and National Health Care Reform: A Briefing Paper, The American Fertility Society and RESOLVE, January 1993.

The Center for Reproductive Law & Policy
120 Wall Street • New York, New York 10005

SECTION V: NON-DISCRIMINATION.[9]

(A) Except as provided in Section V (B), government shall not discriminate against, deny, or condition the receipt of any form of aid, assistance, benefits or penalties to:

(1) an otherwise eligible person because of a decision to choose or refuse contraception; choose or refuse an abortion or continue a pregnancy;

(2) an otherwise eligible health care facility because that facility provides, provides funding for, or makes referral for abortion, contraception, or childbirth services.

(B) When it provides, provides funding for, or makes a referral for reproductive health services, government shall act neutrally so not to favor one childbearing choice over another. Medical care provided with government funds, employees, under benefit plans, or by contract with the government shall include services related to abortion to the same extent as other pregnancy related services.

(C) CONSCIENCE CLAUSE.[10] Nothing in this Act shall be construed to require any health care professional to provide or assist in providing abortion or contraceptive services when the refusal to provide or assist in providing these services is based upon religious or conscientious belief; provided that, when exercising this exemption,

[9] Section V is intended to reverse *Maher v. Roe*, 432 U.S. 464 (1977), *Harris v. McRae*, 448 U.S. 297 (1980), *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989), and *Rust v. Sullivan*, 111 S. Ct. 1759 (1991), and to impose principles of non-discrimination and neutrality in all governmental programs. Section B mirrors the language of the Reproductive Health Equity Act and establishes the neutrality principle.

[10] Abortion opponents will object to any act that does not contain a conscience clause. I have included one here to avoid a protracted debate about the rights of Catholic doctors to refuse to provide abortion and birth control. The provision, however, applies only to individuals, not religious hospitals, because many religious institutions function as public institutions. They provide care to all persons and allow non-religious doctors to use their facilities. The exemption only allows medical personnel to refuse to provide services because of a bona-fide religious or conscientious belief, not because the service is too controversial. It also requires those exercising religious or conscientious objection to make an appropriate referral for care.

This is a detailed diagram of the issues involved
Melissa should you decide to go forward
we'd be
interested in receipt for fees

Medicaid

Hyde amendment/draft 3
3/31/93 6:30PM

The Administration's Position

What Has the Administration Done?

The Toner article represents the Administration as seeking the "repeal" of the Hyde amendment, and our briefers have used this language in talking with the press. Unfortunately, it is not wholly accurate. The Hyde amendment dies at the end of each Congress and must be reintroduced and passed by the new Congress. Rather, the administration's 1994 budget does not affirmatively include the Hyde amendment as part of its submission.

This may seem like a small point, but it's important. It's one thing for the President to deliberately pick a fight with existing law, but that's not what he did. Instead, this committed pro-choice president refrained from putting his seal of approval on the Hyde amendment by resubmitting it to the Congress in his own name.

At the same time, the administration has committed itself to work with the Congress to facilitate an approach that respects both Federal and State law. [NB: The actual language of the budget talks about an approach that is "consistent with" both bodies of law--a logical impossibility, unfortunately. I'm told that the budget has already been printed and that this language cannot be changed.]

The legal consequences of simply not passing the Hyde amendment are not entirely clear. Some states would certainly enjoy increased flexibility to fund procedures that they are now prohibited from supporting through the Medicaid program.

Other states, however, would probably be required to fund some procedures defined as medically necessary by Medicare law and/or the courts that these states now refrain from funding. Because the President, who is strongly pro-choice, believes that state flexibility is an important goal, the administration will work with the Congress to find an approach that is consistent with that goal.

Some likely questions with proposed answers

What does the budget language mean substantively?

We are committed to working with the Congress and the states on this matter. That process hasn't even begun, and at this point there's no way of saying what it will produce.

Your budget document talks about an approach that is "consistent with both federal and state law." But don't they contradict one another? Isn't that the problem?

The answer is, we don't know yet. The existing case law on the scope of Medicaid requirements is not clear and definitive. That's one of the things we'll have to study. But the thrust of the budget language is clear: we're working for an approach that balances the legitimate interests and concerns reflected in both bodies of law.

Didn't you say yesterday that a straight repeal was all that is required and that there would be no need for further federal legislation?

The answer is, we don't know yet, but some additional language may be required. If so, we're committed to working with the Congress to draft it.

Your budget document doesn't include funding for the increased number of Medicaid abortions that just about everybody thinks would result without the Hyde amendment. Do you plan to request additional funds for this purpose?

It's by no means clear what the net funding implications of this change will be. The budget will stand as the President has presented it.

Will abortion or reproductive services be part of the minimum benefit package required under health care reform?

As we've said time and time again, we're not going to comment on the President's package until it's announced.

But doesn't this create a precedent for that package?

Look, right now we have laws--including Medicaid--on the books, and we have to work within that context. The overall health reform package will create a new context, and we'll face new issues.

Let me give you an example of what I mean. Last week HHS granted the state of Oregon a waiver for an experimental design of its Medicaid program, but the Oregon package doesn't set a binding precedent for our general health care program.

Does the President's budget proposal mean that he will accept the District of Columbia using its own funds for abortion?

We have no decision or announcement on that yet. But let me repeat, the President believes that local flexibility is an important objective.

Melanne—

4/6/93 b.t.

TALKING POINTS ON REPEAL OF BAN ON FEHB COVERAGE OF ABORTION

I. CURRENT LAW

The Treasury/Postal Appropriations bill for the current fiscal year provides that "no funds appropriated by this Act shall be available for an abortion, or the administrative expenses in connection with any health plan under the Federal employees health benefit program which provides any benefits or coverage for abortions... [except] where the life of the mother would be endangered if the fetus were carried to term."

This provision has prevented federally employed women, and dependents of federal employees, from obtaining abortions under their Federal health insurance plans.

II. HISTORY

The restriction was established in 1982 after a court battle over Reagan Administration attempts to do this administratively. Previously, most FEHB plans (not all) covered abortion.

III. BUDGET PROPOSAL

As with the Hyde amendment, the FY 1994 President's budget does not propose continuation of this restriction. It indicates that the Administration will work with the Congress to facilitate an approach that is consistent with both Federal and state law.

IV. FAIRNESS

Many private health care plans cover abortion services as part of their coverage of reproductive health services generally. Coverage varies widely, and we don't have enough information at this time to be able to characterize the proportion of those which do. We hope to get more information on this.

V. PROCESS

The Office of Personnel Management sent out its annual call letter on 3/31/93 to health insurance plans asking them to submit proposals for 1994 coverage, rates, etc. The letter neither requires plans to provide abortion benefits nor precludes them from doing so. Those who wish to provide abortion benefits will probably submit proposals with and without abortion. If the restriction is not continued, OPM would <u>permit but not require</u> plans to offer these benefits beginning with the 1994 contract (calendar) year. Federal employees will thus have the option of choosing (and paying for) a health benefits plan which covers abortion.

VI. COST

There are no reliable cost figures. Employees currently contribute about 28% of premium costs, while the Federal government contributes the remainder, but it's difficult to determine how insurance carriers would price it.

VII. HEALTH CARE REFORM

No decisions have been made regarding the services to be included in the President's health care reform proposal.

456. [redacted]
6249

NARAL

NARAL

FAX Transmission Cover Sheet

FAX Numbers:	(202) 973-3097 (202) 973-3098 (202) 973-3099	1156 15Th Street, NW Suite 700
Phone:	(202) 973-3000	Washington, DC 20005

Date: April 7, 1993

From: James Wagoner

To: Milanne Vervoer

This is page 1 of 8 **pages.**

If all pages are not received, please call us.

Comments: Milanne —

Attached is the generic pro-choice vote card for the House and Senate (This is the combined NARAL/Planned Parenthood count).

What's unknown is where these members will be on a specific issue which is supported by a pro-choice president. We've never had that before! Thanks,

James

National Abortion Rights Action League

1156 15th Street N.W. #700
Washington D.C. 20005
202-973-3000

April 1, 1993

SENATE COMPOSITION ON CHOICE - 103rd CONGRESS

PRO (52)	MIXED (10)	ANTI (38)
Akaka (D-HI)	Conrad (D-ND)	Bennett (R-UT)
Baucus (D-MT)	Dorgan (D-ND)	Bond (R-MO)
Biden (D-DE)	Gorton (R-WA)	Burns (R-MT)
Bingaman (D-NM)	Kassebaum (R-KS)	Coats (R-IN)
Boren (D-OK)	Nunn (D-GA)	Cochran (R-MS)
Boxer (D-CA)	Roth (R-DE)	Craig (R-ID)
Bradley (D-NJ)	Simpson (R-WY)	D'Amato (R-NY)
Brown (R-CO)	Stevens (R-AK)	Danforth (R-MO)
Bryan (D-NV)	Warner (R-VA)	Dole (R-KS)
Bumpers (D-AR)	Wofford (D-PA)	Domenici (R-NM)
Byrd (D-WV)		Durenberger (R-MN)
Campbell (D-CO)		Faircloth (R-NC)
Chafee (R-RI)		Gramm (R-TX)
Cohen (R-ME)		Grassley (R-IA)
Daschle (D-SD)		Gregg (R-NH)
Dodd (D-CT)		Hatch (R-UT)
Feingold (D-WI)		Hatfield (R-OR)
Feinstein (D-CA)		Helms (R-NC)
Glenn (D-OH)		Johnston (D-LA)
Graham (D-FL)		Kempthorne (R-ID)
Harkin (D-IA)		Lott (R-MS)
Hollings (D-SC)		Lugar (R-IN)
Inouye (D-HI)		Mack (R-FL)
Jeffords (R-VT)		McCain (R-AZ)
Kennedy (D-MA)		McConnell (R-KY)
Kerrey (D-NE)		Murkowski (R-AK)
Kerry (D-MA)		Nickles (R-OK)
Kohl (D-WI)		Pressler (R-SD)
Kreuger (D-TX)		Reid (D-NV)
Lautenberg (D-NJ)		Smith (R-NH)
Leahy (D-VT)		Thurmond (R-SC)
Levin (D-MI)		Wallop (R-WY)
Lieberman (D-CT)		
Mathews (D-TN)		Breaux (D-LA) *
Metzenbaum (D-OH)		DeConcini (D-AZ) *
Mikulski (D-MD)		Exon (D-NE) *
Mitchell (D-ME)		Ford (D-KY) *
Moseley-Braun (D-IL)		Heflin (D-AL) *
Moynihan (D-NY)		
Murray (D-WA)		Coverdell (R-GA) ?
Packwood (R-OR)		
Pell (D-RI)		
Pryor (D-AR)		
Riegle (D-MI)		
Robb (D-VA)		
Rockefeller (D-WV)		
Sarbanes (D-MD)		
Sasser (D-TN)		
Shelby (D-AL)		
Simon (D-IL)		
Specter (R-PA)		
Wellstone (D-MN)		* Possible Cloture

HOUSE CHOICE LIST, 103RD CONGRESS			
	PRO-CHOICE - 195	MIXED - 66	ANTI - 170
AK			Young-R
AL	Cramer-D Hilliard-D	Browder-D	Bachus-R Bevill-D Callahan-R Everett-R
AR	Lambert-D	Thornton-D	Dickey-R Hutchinson-R
AZ	Coppersmith-D English-D Pastor-D	Kolbe-R	Kyl-R Stump-R
CA	Becerra-D Beilenson-D Berman-D Brown-D Dellums-D Dixon-D Dooley-D Edwards-D Eshoo-D Fazio-D Filner-D Hamburg-D Harman-D Horn-R Huffington-R Lantos-D Lehman-D Martinez-D Matsui-D Miller-D Minata-D Pelosi-D Roybal-Allard-D Schenk-D Stark-D Torres-D Tucker-D Waters-D Waxman-D Woolsey-D	Calvert-R Condit-D Kim-R McCandless-R Thomas-R	Baker-R Cox-R Cunningham-R Doolittle-R Dornan-R Dreier-R Gallegly-R Herger-R Hunter-R Lewis-R McKeon-R Moorhead-R Packard-R Pombo-R Rohrabacher-R Royce-R
CO	Schroeder-D Skaggs-D	McInnis-R	Allard-R Hefley-R Schaefer-R
CT	DeLauro-D Gejdenson-D Johnson-R Kennelly-D Shays-R	Franks-R	
DE	Castle-R		

FL	Bacchus-D Brown-D Deutsch-D Hastings-D Johnston-D Meek-D Peterson-D Thurman-D	Fowler-R Gibbons-D Miller-R	Bilirakis-R Canady-R Diaz-Balart-R Goss-R Hutto-D Lewis-R McCollum-R Mica-R Ros-Lehtinen-R Shaw-R Stearns-R Young-R
GA	Bishop-D Deal-D Johnson-D Lewis-D McKinney-D	Darden-D Rowland-D	Collins-R Gingrich-R Kingston-R Linder-R
HI	Abercrombie-D Mink-D		
IA	Smith-D	Leach-R	Grandy-R Lightfoot-R Nussle-R
ID	LaRocco-D		Crapo-R
IL	Collins-D Evans-D Fawell-R Gutierrez-D Reynolds-D Rush-D Yates-D	Durbin-D Porter-R Rostenkowski-D Sangmeister-D	Costello-D Crane-R Ewing-R Hastert-R Hyde-R Lipinski-D Manzullo-R Michel-R Poshard-D
IN	Long-D Visclosky-D	Hamilton-D Jacobs-D McCloskey-D Sharp-D	Burton-R Buyer-R Myers-R Roemer-D
KS	Glickman-D Meyers-R	Slattery-D	Roberts-R
KY		Baesler-D	Barlow-D Bunning-R Mazzoli-D Natcher-D Rogers-R
LA	Fields-D Jefferson-D		Baker-R Hayes-D Livingston-R McCrery-R Tauzin-D

MA	Frank-D Kennedy-D Markey-D Meehan-D Olver-D Studds-D	Torkildsen-R	Blute-R Moakley-D Neal-D
ME	Andrews-D Snowe-R		
MD	Cardin-D Gilchrest-R Hoyer-D Mfume-D Morella-R Wynn-D		Bartlett-R Bentley-R
MI	Carr-D Collins-D Conyers-D Dingell-D Ford-D Levin-D	Benier-D Upton-R	Barcia-D Camp-R Henry-R Hoekstra-R Kildee-D Knollenberg-R Smith-R Stupak-D
MN	Minge-D Sabo-D	Penny-D Ramstad-R Vento-D	Grams-R Oberstar-D Peterson-D
MO	Clay-D Wheat-D	Danner-D Gephardt-D	Emerson-R Hancock-R Skelton-D Talent-R Volkmer-D
MS			Montgomery-D Parker-D Taylor-D Whitten-D
MT	Williams-D		
NC	Clayton-D Neal-D Price-D Rose-D Valentine-D Watt-D	Hefner-D Lancaster-D	Ballenger-R Coble-R McMillan-R Taylor-R
ND		Pomeroy-D	
NE	Hoagland-D		Barrett-R Bereuter-R
NH		Swett-D Zeliff-R	

NJ	Andrews-D Gallo-R Hughes-D Klein-D Menendez-D Pallone-D Payne-D Roukema-R Torricelli-D Zimmer-R	Franks-R	Saxton-R Smith-R
NM	Richardson-D	Schiff-R	Skeen-R
NV		Bilbray-D	Vucanovich-R
NY	Ackerman-D Boehlert-R Engel-D Flake-D Gilman-R Hinchey-D Houghton-R Lowey-D Maloney-D Molinari-R Nadler-D Owens-D Rangel-D Schumer-D Serrano-D Slaughter-D Towns-D Velazquez-D	Hochbrueckner-D Lazio-R Levy-R McHugh-R McNulty-D	Fish-R King-R LaFalce-D Manton-D Paxon-R Quinn-R Solomon-R Walsh-R
OH	Brown-D Fingerhut-D Sawyer-D Stokes-D Strickland-D Traficant-D	Hobson-R Hoke-R Mann-D Pryce-R Regula-R	Applegate-D Boehner-R Gillmor-R Hall-D Kaptur-D Kasich-R Oxley-R
OK	Brewster-D McCurdy-D Synar-D	English-D	Inhofe-R Istook-R
OR	DeFazio-D Furse-D Kopetski-D Wyden-D		Smith-R

PA	Blackwell-D Coyne-D Foglietta-D Greenwood-R Mezvinsky-D	Gekas-R McHale-D Ridge-R	Borski-D Clinger-R Goodling-R Holden-D Kanjorski-D Klink-D McDade-R Murphy-D Murtha-D Santorum-R Shuster-R Walker-R Weldon-R
RI	Machtley-R Reed-D		
SC	Clyburn-D Derrick-D Spratt-D	Ravenel-R	Inglis-R Spence-R
SD		Johnson-D	
TN	Cooper-D Ford-D Gordon-D Lloyd-D Tanner-D	Clement-D	Duncan-R Quillen-R Sundquist-R
TX	Andrews-D Brooks-D Bryant-D Coleman-D Edwards-D Frost-D Gonzalez-D Green-D Johnson-D Pickle-D Washington-D Wilson-D	Bonilla-R Chapman-D Geren-D	Archer-R Armey-R Barton-R Combest-R de la Garza-D DeLay-R Fields-R Hall-R Johnson-R Laughlin-D Ortiz-D Sarpalius-D Smith-R Stenholm-D Tejeda-D
UT	Shepherd-D		Hansen-R Orton-D
VT	Sanders-I		
VA	Boucher-D Byrne-D Moran-D Payne-D Pickett-D Scott-D Sisisky-D		Bateman-R Bliley-R Goodlatte-R Wolf-R

WA	Cantwell-D Dicks-D #Foley-D Inslee-D Kreidler-D McDermott-D Swift-D Unsoeld-D	Dunn-R	
WI	Barrett-D Obey-D	Gunderson-R Kleczka-D Klug-R	Petri-R Roth-R Sensenbrenner-R
WV	Wise-D		Mollohan-D Rahall-R
WY			Thomas-R

(Vacancies in California, Mississippi, Ohio and Wisconsin.)

Health Plan Likely to Cover Abortions

■ **Benefits:** The Administration will include the elective procedure in its basic medical package, knowledgeable sources predict. Strong opposition is expected. A1

By MARLENE CIMONS and EDWIN CHEN, TIMES STAFF WRITERS

WASHINGTON—The Clinton Administration plans to include coverage for elective abortions in the basic package of medical benefits guaranteed to all Americans under the health care reform proposal now taking shape, knowledgeable sources said Tuesday.

Although some members of the task force have expressed fears that abortion coverage could jeopardize support for the overall health care plan, the dominant feeling is that "there is no choice" but to cover abortion because President Clinton has clearly staked out his position on the subject, said one source involved in the process.

"The feeling is that this man has committed himself to making abortion available and secure as a legal right, and it's something that a health care system has to include," the source said. "My sense politically is that it would cause more problems if it wasn't in there than if it was."

Task force members believe that opponents in Congress eventually can be won over by the argument that many private plans already cover abortion, and, for the most part, "we're not talking about using federal funds to pay for it," one source said. Most Americans would continue to be covered by privately funded health plans under the proposed reforms with the government subsidizing insurance for the 37 million people who have no coverage and cannot afford to pay.

Providing coverage for abortions would be consistent with a series of actions Clinton has taken in the first months of his presidency that further abortion rights.

During his first week in office, for example, he overturned the "gag rule" that restricted abortion counseling at federally funded family planning clinics, decided to allow abortions at U.S. military hospitals overseas and reversed a 1984 order, known as the Mexico City policy, which prevented the United States from providing foreign aid to overseas organizations

Please see BENEFITS, A8

that perform or promote abortion.

And last week, in his first budget, Clinton proposed removing abortion restrictions that long have been included in appropriation bills, including bans on abortion coverage in federal employee health insurance plans.

Under the proposed health care system, every American would have health insurance and would be guaranteed access to a nationally mandated package of benefits, probably determined by a national health care board. The benefits package would serve as a model against which all plans in the country would be measured.

Abortion foes Tuesday said that they expect a legislative battle on Capitol Hill if the health reform benefits package includes abortion.

"We would strongly oppose any mandate on the part of the federal government that compelled employers, health care providers and citizens to collaborate in abortion on demand," said Douglas Johnson, legislative director for the National Right to Life Committee. "We would hope that the pro-abortion movement wouldn't try to hijack the national health plan."

David Kush, a spokesman for Rep. Christopher H. Smith (R-N.J.), a leading abortion opponent in the House, said: "Any plan that puts abortion into the national health care system will be opposed. It will force members from the undecided column into the opposed column."

Bruce Fried, a Washington health care lobbyist who advised the Clinton transition team, predicted that the move probably would cause problems but ultimately would not thwart reform.

"For those who want to oppose health care reform, this will be another reason to do it," he said. "So it really will put him [Clinton] in a difficult position. But on balance, it's not going to make or break the political dynamics of this thing."

The extent to which elective abortion is currently covered by insurance plans is unclear because the issue is poorly documented, health policy experts said.

"This is an untalked-about area," said William S. Custer, research director of the Employee Benefit Research Institute.

While medically necessary abortions are covered by the vast majority of employer-based insurance plans, the scope of private insurance coverage for elective abortions "has never been quantified, to my knowledge," Custer added.

Although no final decisions have been made by the health care reform task force headed by First Lady Hillary Rodham Clinton, some task force members believe that the best way to handle the issue is to include abortion within the general area of "reproductive health services" without being specific, sources said.

"There probably won't be a line that says 'abortion rights,' but 'full reproductive rights' will be in there," said one congressional source.

One source present during White House meetings where the benefits package was discussed agreed, saying: "There are some ways to finesse this issue so that it doesn't get embroiled in controversy."

He predicted that "there will be controversy in Congress, but that isn't the Administration's problem—or its fault. Clinton has to do this politically or the people who voted for him will raise more of a ruckus than the people who didn't."

Numerous health policy analysts said Tuesday that they were not surprised by the decision to cover elective abortion and agreed that it is likely to cause controversy.

"He [Clinton] campaigned as a pro-choice candidate," noted Drew E. Altman, president of the Henry J. Kaiser Family Foundation, a health care philanthropy organization based in Menlo Park, Calif.

"Because of his commitment to choice and to a full range of services in a basic benefits package, you can't design a package without it," Altman said.

"The danger is that this one issue will create enough heat to cause real problems for the overall plan, which is hardly going to be for want of controversy to begin with. But I really think he has no choice."

Kate Michelman, president of the National Abortion Rights Action League, said that she believes it is time for abortion to be regarded as "a medical issue," since many women initially enter the health care system when they need reproductive health services.

"Health care reform and this benefits package is going to affect everybody in the country, so if they choose to exclude abortion, this would mean that not only poor women would lose abortions as an option, but all of us who now have it covered under private health insurance plans would lose it," she said. "We're no longer talking about poor women and federal funds; we're talking about all women."

193

Clinton Urged to Halt Warming of Hanoi Ties

By MICHAEL ROSS
TIMES STAFF WRITER

WASHINGTON—Veterans groups and POW activists, citing new evidence that Hanoi lied about the number of American prisoners it held during the Vietnam War, urged President Clinton on Tuesday to halt further steps toward normalizing relations with Vietnam until it turns over all of its POW records.

"The so-called road map for normalization of relations with Vietnam should be rolled up, put on a dark shelf and forgotten," American Legion spokesman Richard Christian said.

Referring to the step-by-step program for re-establishing relations that Clinton inherited from

Please see POWS, A4

Continued from A1

the Bush Administration, Christian and other leaders of veterans groups announced that they are embarking on a national campaign to freeze the process pending answers to new questions raised by the explosive discovery of a secret 1972 document, which indicates that Vietnam held twice as many American prisoners during the war as it has admitted.

Discovered early this year by an American researcher in the Moscow archives of the Soviet Communist Party and turned over to the Clinton Administration last week, the document purports to be a Russian translation of a classified report by a senior North Vietnamese general, who in September, 1972, reported to the North Vietnamese Politburo that Hanoi held 1,205 American prisoners of war.

The number is 837 more than North Vietnam was admitting at the time and at least 600 more than were repatriated during a 1975 prisoner exchange.

Clearly hoping to prevent what could be a major setback in the normalization process, senior Vietnamese officials asserted in Hanoi on Tuesday that the document was a fake and suggested that it had been planted in the Russian archives by unnamed American interests who oppose normal U.S.-Vietnamese relations.

That claim, however, was quickly dismissed by intelligence analysts and congressional investigators who have seen the document and are reviewing it. While the accuracy of its information has yet to be determined, there is "virtually no question but that it is authentic," one intelligence analyst familiar with the document said.

"It is real, but whether it is accurate is another question," added a congressional investigator, who noted that some of the details it contained on the prisoners appeared to be incorrect.

He noted, for instance, that the report, by Gen. Tran Van Quang, deputy chief of staff of Vietnam's army, boasted that among the prisoners were two who had been trained as astronauts and 16 who held the rank of colonel—statistics that do not match U.S. records.

But the intelligence analyst and other sources added that these discrepancies do not by themselves cast doubt on the authenticity of the document. The Vietnamese system of military ranks differs from the American system, the analyst noted, and further confusion could have crept into the document when the prisoners' ranks were translated from English to Vietnamese to Russian and finally back into English again.

The document given to former Ambassador Malcolm Toon, the head of the American delegation to a joint U.S.-Russian commission investigating POWs, by his Russian counterpart, Gen. Dmitri A. Volkogonov, in Moscow last Thursday was an English translation of the purported Russian version of Quang's 1972 Politburo report.

Pentagon spokesman Bob Hall said Tuesday that the authenticity and implications of the document will be the main subject of discussions with Vietnamese officials by Gen. John W. Vessey Jr., the President's special emissary, when he visits Hanoi later this week.

The purpose of Vessey's mission had been to report on Vietnam's progress in accounting for missing American servicemen. But answering the questions raised by the Quang report has now become the overriding aim of the general's next visit. "We'd like to see the original Vietnamese document if one exists and . . . we are going to be raising this with the Vietnamese," Hall said.

In the meantime, the furor created by the document appeared certain to reopen old wounds among POW activists, stir up the anguish long felt by POW families and at least temporarily freeze the careful process toward normal relations nurtured first by President George Bush and carried on by President Clinton.

The Clinton Administration had been in the middle of a high-level review of U.S. policy toward Vietnam with the aim of lifting the trade embargo imposed after the Vietnam War.

The International Monetary Fund and the World Bank are meeting at the end of April, and, under Japanese and French pressure, may decide to grant new international assistance to Vietnam. While normal U.S.-Vietnamese relations have been delayed by the POW issue, American businesses fear that they will lose lucrative contracts to European and Asian competitors if the embargo is not lifted before the IMF and World Bank loans are granted.

But at a news conference Tuesday on Capitol Hill, major veterans' organizations joined with POW family groups and lawmakers to announce the start of a new campaign to keep the embargo in place until Vietnam accounts for the more than 2,200 American servicemen still officially listed as missing two decades after the Vietnam War.

"We stand united in strong opposition to normalizing relations, relaxing the trade embargo . . . and certainly to any IMF or World Bank loans" in view of "this dramatic new information that has surfaced regarding the perfidy of the Vietnamese," said Sen. Robert C. Smith (R-N.H.), a longtime POW activist in Congress and vice chairman of a yearlong Senate investigation into the fate of missing American servicemen.

"Vietnam veterans do not accept that there has been adequate cooperation from Vietnam" in resolving the POW issue, and the trade embargo "is the only real leverage we have to resolve it," added J. Thomas Burch Jr., chairman of the National Vietnam Veterans Coalition.

Along with Smith, the groups sent a letter to Clinton on Tuesday urging him to oppose the multinational loans and retain the embargo until the POW issue is resolved. Joining in the appeal were the American Legion, the National League of Families, the National Alliance of Families, Vietnam Veterans of America and several other veterans and family groups.

April 22, 1993

MEMORANDUM

TO: Melanne Verveer
Mandy Grundwald

FROM: Linda Bergthold

RE: **ABORTION COVERAGE IN PRIVATE PLANS**

Attached is the information you requested on states that restrict abortion coverage in private insurance plans. I have also attached a description of state laws that restrict abortion coverage for state employees.

What restrictions are placed on abortion in private plans?

There are five states that limit or prohibit the coverage of abortion in private plans. All but Pennsylvania allow a separate rider to be sold for coverage of abortions under specific circumstances. The restrictions in Missouri and Rhode Island were both challenged in court. The Rhode Island limitation was ruled unconstitutional. The Missouri limitation was upheld. Neither case was heard by the Supreme Court.

What restrictions are placed on abortion for state employees?

Five states (including Pennsylvania which also restricts private plans) restrict abortion coverage in insurance plans offered to state employees. These restrictions generally invoke state prohibitions on the use of public funds for abortion coverage.

How many private plans cover abortion?

We have thorougly researched this issue and cannot provide you with reliable numbers on the proportion of all private insurance plans that cover abortion. However, in conversations with legal scholars, private insurers, and large self-insured employers, I am told that **most private insurance plans cover abortion implicitly,** unless a company specifically requests the insurance company to exclude abortion.

How much does it cost to cover abortion in private plans?
The cost of abortion is a negligible factor in the premium and most companies cannot even quantify it, because the cost of this service is calculated as the **risk of pregnancy if taken to term, not the cost of an abortion.** Insurance underwriters regard the inclusion of abortion as a way to limit overall costs.

STATE LAWS RESTRICTING ABORTION COVERAGE IN INSURANCE PLANS FOR STATE EMPLOYEES

Five states (Colorado, Illinois, Massachusetts, Nebraska, and Pennsylvania) have laws that restrict abortion coverage in insurance plans for state employees. These state mandates, along with hundreds of others, will be preempted by federal health care reform legislation.

Colorado -- The Attorney General has issued an opinion stating that group health insurance provided by the state for its employees must exclude coverage for abortions in accordance with the state constitution's prohibition on the use of state funds for abortions. 1985 Colo. AG LEXIS 28 (Feb.6, 1985); Colo. Const. art. V, sec. 50 (amended 1985).

Illinois -- Group health insurance for state employees must exclude coverage for abortions unless necessary to preserve the life of the woman. Health benefits for abortion may be available on an optional basis through an HMO if a premium for such coverage is paid by the member. Ch. 127, ¶¶ 526, 526.1.

Massachusetts -- Health insurance paid for by the state or a subdivision thereof for government employees and retirees (and their dependents) may not provide coverage for abortion unless the abortion is found by a panel of qualified physicians to be necessary to prevent the death of the woman. Ch. 32A, Sections 4, 10B, 10C, 12, 14; Ch. 32B, Sections 3, 3A, 11C, 16.

Nebraska -- No group insurance contract or HMO agreement paid for in part with public funds may include coverage for abortion not necessary to prevent the woman's death. Section 44-1615-01.

Pennsylvania -- No health plan for employees, funded with any Commonwealth funds, shall include coverage for abortions unless an independent physician certifies that an abortion is necessary to avert the death of the woman or unless the pregnancy is the result of reported rape or incest. Title 18, Section 3215(D)

STATE LAWS RESTRICTING ABORTION COVERAGE IN PRIVATE INSURANCE

Six states (Idaho, Kentucky, Missouri, North Dakota, Pennsylvania, and Rhode Island) have passed laws that restrict abortion coverage in private insurance plans. One state's law (Rhode Island) has been ruled unconstitutional and is not in effect. These state mandates, along with hundreds of others, will be preempted by federal health care reform legislation.

Idaho (*) -- Disability insurance policies, individual insurance policies, and HMO policies must exclude coverage for abortions not necessary to preserve the woman's life. Coverage for other abortions may be obtained only if the insurance company elects to offer it and a separate premium is paid. Sections 41-2142, 41-2210A, 41-3439, 41-3934.

Kentucky (*) -- No health insurance contracts, plans, or policies can provide coverage for abortions not necessary to preserve the woman's life unless an optional rider is obtained and a separate premium is paid. This provision applies to plans offered by insurance companies, HMOs, self-insured employers. Section 304.5-160.

Missouri (*) -- No health insurance contracts, plans, or policies can provide coverage for abortions other than spontaneous abortions or abortions necessary to prevent the death of the woman unless an optional rider is obtained and a separate premium is paid. Section 376.805.

North Dakota -- No health insurance contracts, plans, or policies can provide coverage for abortions other than abortions necessary to prevent the death of the woman unless an optional rider is obtained and a separate premium is paid. Section 14-02.3-03.

Pennsylvania -- All insurers who make available health care and disability insurance must offer policies that contain an express exclusion for abortion services not necessary to avert the death of the woman or to terminate pregnancies caused by rape or incest. Title 18, Section 3215(E).

Rhode Island -- All health insurance contracts, plans, and policies must exclude coverage for abortion unless the abortion is necessary to preserve the woman's life or resulted from rape or incest unless an optional rider is obtained and an additional premium is paid. Sections 27-18-28, 36-12-2.1 (This law has been ruled unconstitutional.)

(*) These statutes use the term "elective" abortions, defined as any abortion for any reason other than to preserve the woman's life.

THE WHITE HOUSE

WASHINGTON

TO: Ricki Seidman
Melanne Verveer

FROM: Carol H. Rasco CHR

SUBJ: Abortion

DATE: April 14, 1993

I understand the two of you are co-chairing a subcommittee to examine the abortion/reproductive rights issue within the context of health care reform. I want to suggest that the scope be expanded somewhat or perhaps you are already including the issues I will outline here or at least we explore how to handle the matters outlined below. This all began to crystalize for me when I met last Friday with Marcia Greenberger and Judy Lichtman along with Bill Galston and Walter Dellinger.

Marcia and Judy basically brought up six issues on which they feel their organizations need guidance from this office: Hyde amendment; the effect of Hyde on federal employees health plan which comes up for a vote in the Post Office and Government Operations Committee at the end of May; health care reform; DC appropriation; Supreme Court nominee; and the Freedom of Choice act which they would like to see underway very quickly. I believe Walter said he is preparing a memo to President on Freedom of Choice?

As part of the meeting they agreed to send to Bill Galston any information they can get on timelines of the various issues, analysis of funding with Freedom of Choice interactions; and the relationships between Medicaid law and state statutes, legislation, constitutions, etc. Additionally they have agreed to send a copy of a recent CQ article pertinent to these issues. Bill will share with all of us this information as it arrives.

It seems to me we need to look at all this comprehensively; do we need a meeting? have you already begun to cover this? suggestions? I do feel I need to get back to them with guidance from here...

Thanks.

cc: Bill Galston
Walter Dellinger
Bob Boorstein

Abortion issues could trip up health-care reform

By Mimi Hall
USA TODAY

The Clinton administration is wrestling with abortion coverage in its basic package of health-care benefits, aware that the explosive issue could jeopardize — or at least stall — congressional passage of health-care reform.

"When members of Congress see this, they will draw the line," says David Kush, spokesman for Rep. Chris Smith, R-N.J., an abortion foe. "There is going to be a fight."

Clinton said in January that he wanted his health-care overhaul to provide "access to quality, affordable health care, including abortion services."

Already, he has fulfilled a promise to lift Republican-era abortion restrictions affecting poor women and women in the military abroad.

MARALDO: 'We know there's going to be a fight.'

By including abortion benefits in his health-care plan, due in mid-May, Clinton would continue efforts to make abortion available to all women.

"You could say that this is going to be the defining moment for reproductive rights in America, because we're talking about having abortion as a basic benefit for every American woman," says Planned Parenthood President Pamela Maraldo. But "we know there's going to be a fight."

With abortion covered, insurers would have to offer the benefit to all, including the 37 million uninsured people to be brought into the system.

Abortion foes complain that would force everyone, no matter what their views on abortion, to indirectly pay for abortions through insurance premiums or tax dollars.

And they're counting on many abortion-rights supporters in Congress to join their fight in saying that goes too far.

"A lot of members of Congress draw the line between making (abortion) legal and requiring people to pay for it," says Kush.

But abortion-rights activists promise a fight if abortion is not included. Analysts say that leaves Clinton at political risk no matter what he does.

"He's made a personal commitment about reproductive health services and abortion services, and it would be very difficult now to exclude coverage for abortion services," says Drew Altman of the Henry J. Kaiser Family Foundation, a health-care philanthropy.

Experts and activists on both sides of the issue say Hillary Rodham Clinton's health-care task force is looking at several issues on abortion:

▶ Whether to explicitly include abortion or to include a vague mandate that all reproductive care be covered.

"The challenge is how to put it in the plan and minimize the damage," Altman says.

▶ How to provide the benefits if there is no doctor willing to perform abortions in a patient's network, the system of health providers expected to be a key part of the reform plan. That could be a common scenario, given the nationwide shortage of abortion doctors.

▶ What to do about five states — Idaho, Kentucky, Missouri, North Dakota and Rhode Island — that require private insurance companies to exclude most abortion benefits.

"The federal government has no business mandating" benefits, says Doug Johnson of the National Right to Life Committee. "We're saying it should be kept optional."

Says Helen Alvare of the National Conference of Catholic Bishops: "It will become one of the hottest issues, and . . . that's a shame because health-care reform is so badly needed."

THURSDAY, APRIL 15, 1993 · USA TODAY

Russia aid plan to top $30 billion

By Koji Sasahara, AP

CRAFTING AID PLAN: Secretary of State Warren Christopher is flanked by Japanese Prime Minister Kiichi Miyazawa, left, and Russian Foreign Minister Andrei Kozyrev at a dinner in Tokyo.

By Johanna Neuman
USA TODAY

The world's seven largest industrial nations today unveil a package of aid for Russia expected to top $30 billion, including an expected $1.8 billion from the United States.

Backing embattled Russian President Boris Yeltsin with money as well as words, the U.S. pledge would be over and above the $1.6 billion pledged by President Clinton at the recent Vancouver summit.

The money would come from the U.S. foreign aid budget, now at $15 billion, out of a 1994 federal budget of $1.5 trillion. Also proposed: creation of a $4 billion privatization fund, including a $500 million contribution from the United States.

In Tokyo, Treasury Secretary Lloyd Bentsen asked the other nations jointly to contribute $1.5 billion, with $2 billion from the World Bank and the European Bank for Reconstruction and Development.

Secretary of State Warren Christopher explained the rationale, saying "Yeltsin is far superior to any of his likely successors," and citing the likelihood of "benign foreign policy" under Yeltsin, including nuclear reduction treaties.

In another boost to Yeltsin, foreign ministers from the seven nations — Britain, Canada, France, Germany, Italy, Japan and the United States — agreed to defer any U.N. action to tighten sanctions on Serbia.

Russia, a traditional Serbian ally, votes April 25 on Yeltsin's leadership. Ministers didn't want to alienate voters.

"Russia is now at a critical juncture," Prime Minister Kiichi Miyazawa of Japan said in opening the meeting. Other nations must "send a clear message" they expect Russia's reforms to succeed.

Miyazawa, en route to Washington for Friday's meeting with Clinton, said Japan will pledge $1.82 billion — including $320 million in grants, $1.5 billion in loans and $100 million in food and medicine.

But Bentsen said Clinton expects Japan to do more.

"Given the strength of the (Japanese) economy, I'm sure the president will be urging them to participate," he said.

But Germany told the others it had reached the limit of its support — $39 billion in aid.

▶ Yeltsin vote, 6A

REVISED 4/5/93
(Revisions in bold and underlined)

March 10, 1993

DRAFT CONFIDENTIAL MEMORANDUM

TO: HILLARY RODHAM CLINTON

FROM: LINDA BERGTHOLD
ROBERT VALDEZ

cc: Chris Jennings
Ira Magaziner
Judy Feder
Atul Gawande

RE: PRESIDENT CLINTON'S MEETING WITH CONGRESSIONAL CAUCUS FOR WOMEN'S ISSUES ON THURSDAY, MARCH 11, 1993

Chris Jennings has asked us to prepare a background memo for you in preparation for President Clinton's meeting with the Congressional Caucus for Women's Issues tomorrow.

Members of the benefits coverage working group representing the Congressional Caucus for Women's Issues and Senator Mikulski have indicated serious concerns about the coverage of abortion services in the benefit package and the process for developing options. In President Clinton's meeting with the Caucus on Thursday, we understand that he will be asked specifically about these issues.

BACKGROUND

Our working group was asked to explore all options related to benefit coverage as we proceed through the Tollgates. When the issue of coverage for abortion first came up, several women in our group objected to the fact that we were even considering a "no coverage" option. They said that President Clinton had clearly stated during the campaign that abortion would be covered in the benefit package, and he had not backed away from supporting abortion when this issue confronted Secretary Shalala during preparation for the confirmation hearings.

The women's advocates in our group emphasized that anything less than clear support for abortion coverage now would be a "signal" to women that the President was abandoning his original commitment. Following discussion with you, Atul and Judy asked us to continue developing all options for consideration (see our options in Attachment A).

ISSUES

Should abortion be covered in the core benefit package?

The problems with including abortion services in the core benefit package are clear. There are probably not enough votes in the Senate to pass a health care reform package that explicitly includes abortion. Support in the House may also be weakened.

Excluding abortion from the core benefit package has obvious political implications. Women's groups perceive that abortion service guarantees can or will be addressed as part of overall system reform. Most women perceive that abortion has been promised as part of the core benefit package.

Our working group has included abortion services as part of our recommendation in Tollgate 5, covered as part of "pregnancy related care." We have also told our working group and the women's groups with whom we have been meeting that the inclusion of abortion services in the final package will be a Presidential level decision.

If part of the core, should abortion be implicitly covered as part of pregnancy related care or as a surgical procedure or explicitly identified?

Making abortion an implicitly covered service may postpone direct confrontation for a short time, but the first time someone asks "Is abortion covered?" a direct answer will be required. Subjecting abortion services to medical necessity provisions is strongly opposed by the Congresswomen as well, because it allows for too much ambiguity and returns power over the decision to medical providers. **We are proposing including abortion services as part of pregnancy related care. This care will be subject to**

the same test of "medical necessity or medical appropriateness" as all other services in the guaranteed package. By defining it as "or", we gain the support of the women's groups.

The advocates in our working group have presented **three options** for abortion coverage. The options they have outlined are: 1) Establish a comprehensive reproductive health benefit including family planning, abortion as part of maternity related care, and post-reproductive care; 2) Integrate abortion services into prevention and maternity care; and 3) Cover abortion as part of maternity-related care only. Their options do **not** exclude abortion, make it a state issue, or subject it to medical necessity control.

We have developed several options for covering abortion short of making it a core benefit in Attachment A. We have also attached provisions for covering abortion in selected western countries in Attachment B.

SUGGESTED TALKING POINTS

Given the complexity of this issue and the importance of gaining as much time as possible to resolve differences among supporters, we would suggest the following talking points for the President in tomorrow's meeting:

Reaffirm support for a woman's right to choose and indicate that he and you understand this issue very well.

Explain the importance of maintaining the integrity of the Tollgate process, which requires that all issues and options be explored until the narrowing process begins.

Indicate that treating abortion differently from other issues at this time will create a credibility problem both within the Task Force work groups and outside.

Explain that you want to develop mechanisms that allow all women to have access to the entire range of reproductive services. This

may mean creating provisions or programs outside the benefit package.

Ask for their patience and support during this planning phase. Ask them to work with him to develop options and strategies that will support the passage of the overall health care reform bill and guarantee the woman's right to choose.

ATTACHMENT A
OPTIONS FOR COVERAGE OF REPRODUCTIVE HEALTH SERVICES

Our working group has considered several options related to the coverage of reproductive health services, including abortion. As we prepared our Tollgate papers, we collected information on current coverage of abortion in the U.S. and abroad:

Many European countries cover abortion subject to some conditions **(see Attachment B);**

Data on the coverage of abortion services in U.S. private insurance plans is difficult to obtain. Many private plans implicitly cover these services;

Some HMOs and private insurers cover abortion subject to definitions of "medical necessity" only;

Ten states have laws that require the exclusion of abortion services from at least some private coverage. Only twelve states fund Medicaid abortions for low income women using state funds;

The Hyde Amendment restricts federal funding except in cases where the life of the mother is endangered if the fetus is carried to term.

This patchwork of coverage demonstrates the highly sensitive nature of the coverage and the lack of consensus on financing arrangements in either the public or private sector.

We think that there are four main options for coverage of abortion:

OPTION 1: Exclude abortion services from the core benefit package.

PRO: Mollifies opponents of abortion.

Keeps the focus of health care reform on system change.

CON: Provokes strong attacks by most women's groups and weakens support among critical allies. Would be viewed as a serious breach of commitment by the President.

SUBOPTION A: Make abortion coverage available in a supplemental package, with subsidies for low income women.

PRO: The subsidizing of abortion services for low income women may be acceptable to some women supporters and has good chance of gaining support from moderate groups.

Making abortion coverage a supplemental coverage issue may soften some of the opposition by abortion opponents.

CON: Including abortion in a supplemental package may be seen as backing down from broader support.

OPTION 2: Include abortion services implicitly in the core benefit package as part of maternity related care or outpatient surgery.

PRO: May avoid immediate direct confrontation with opponents of abortion and buy time for building broader support among women's groups.

CON: Strategy becomes apparent as soon as anyone asks, "Is abortion covered or not?"

Raises "medical necessity" issues.

OPTION 3: Mandate states to cover abortion services for low income women.

SUBOPTION A: States could be given the option of covering abortion services.

PRO: Removes issue from central point of attack: federal support for abortion.

Supports states' rights.

CON: Bumping this down to the states will be politically contentious and potentially inequitable.

OPTION 4: Cover abortion services subject to a "medically necessary" provision.

PRO: Treat abortion coverage the same as other services subject to determinations of medical necessity.

CON: Women's groups will strongly object to the language of medical necessity, because of the potentially narrow legal definition of necessity, the violation of privacy concerns, and possibility of abuse by providers.

Within the context of managed competition, providers might withhold these services selectively because of personal convictions. Furthermore, some providers may refuse to provide them altogether by invoking the "conscience clause."

QUESTION: **SHOULD ABORTION SERVICES BE COVERED IN THE CORE BENEFIT PACKAGE?**

ISSUE: During the campaign, President Clinton stated that abortion services would be part of the core benefit package under national health care reform. In the last few months, the President has given clear signals that he supports a woman's right to choose by overturning five abortion restrictions, including the "gag rule," refusing to seek reauthorization of the Hyde Amendment, and proposing coverage for abortions in the federal employee health insurance plans. Should the President now support the coverage of abortions in the core benefit package he sends to Congress next month?

BACKGROUND: There is no clear pattern of coverage of abortion services, either in the U. S. or abroad. Many European countries cover abortion subject to some conditions. Most of this coverage was established before the issue became so polarized. Information about the coverage of abortion services in private insurance plans in the U.S. is difficult to obtain. Many private plans implicitly cover these services by including them under "pregnancy related care." Hawaii covers abortion as "childbirth or other termination of pregnancy." Some HMOs cover abortion subject to "medical necessity" only. Ten states have laws that require the exclusion of abortion services from at least some private coverage. Only twelve states allow Medicaid funds to be used to fund abortions for low income women. This patchwork of coverage and the lack of consensus among Americans about whether to allow abortion and how to fund it, demonstrates the highly sensitive nature of this issue.

There are three main options for coverage of abortion:

OPTION 1: Include abortion services implicitly in the core benefit package as part of maternity related care or outpatient surgery.

Although implicit coverage might avoid immediate direct confrontation with opponents of abortion, the strategy would

become apparent as soon as anyone asks, "Is abortion covered or not?" Including abortion, however, would be consistent with the President's previous record of support and would add Presidential level leadership to the issue. There would certainly be intense debate in Congress over the inclusion of abortion, and limitations would undoubtedly be placed if coverage survived the debate. This option would remove the President from direct blame for its defeat or modification, focussing attention on Congress instead.

OPTION 2: Exclude abortion services from the national core package and leave coverage decisions to the states. A sub-option might be to mandate for coverage at the state level for low income women only through a supplemental package.

By placing the decision at the state level, the President and Congress would be removed from direct attack. Leaving the abortion issue to the states would be consistent with the general principle of state flexibility being followed throughout the reform. The combination of state flexibility with mandates to cover low income women would gain some support among women's groups and soften the opposition of those opposed to all coverage.

Bumping this issue down to the states would be politically contentious and potentially inequitable. Some would accuse the President and Congress of backing down. In a completely flexible arrangement, some states would choose not to cover abortion services at all, perpetuating the current unfairness. Even with a mandate on coverage for low income women, middle class women might face unequal distribution of services.

OPTION 3: Exclude coverage of abortion services in the core benefit package.

This option would mollify opponents of abortion and keep the focus of health care reform on system change, but women's groups and liberal Congress members would view it as a serious breach of commitment by the President. It is even possible that the President could lose key liberal votes for the overall health care reform package by excluding abortion coverage without any alternative strategy.

ABORTION

Deep Divisions Over Specifics Could Be Bills' Undoing

Speaking often of the recent murder of abortion doctor David Gunn in Pensacola, Fla., members of Congress acted on several abortion-related bills the week of March 22, showing a renewed and slightly stronger interest in abortion rights than in the past. The House approved a bill (HR 670) allowing federally funded family planning clinics to refer clients for abortions. A House subcommittee moved a bill that would protect access to abortion clinics (HR 796), and a Senate committee approved legislation (S 25) that explicitly would establish a woman's right to an abortion. However, debate on each bill exposed several fault lines: Many members generally supported abortion rights, but they differed deeply on whether to limit late-term abortions, require parental involvement for minors and allow public funding of poor women's abortions.

Abortion Rights Bill Moves Ahead After Emotional Markup

As it did last year, the Senate Labor and Human Resources Committee has approved 12-5 a controversial bill that explicitly would establish a woman's right to an abortion.

This year the bill (S 25), known as the Freedom of Choice Act, has a chance of becoming law because President Clinton supports abortion rights. Last year it stalled in both chambers because the leadership could not gather enough votes to override a certain veto from former President George Bush. *(1992 Weekly Report, p. 3475)*

Although bill backers no longer need a veto-proof margin of support, members remain deeply divided about specific provisions. Some of those concerns came out during the committee's emotional markup March 24.

In a last-minute decision, senators moved the markup from the committee's spacious hearing room to a small room in the Capitol — which had no space for the five dozen people who thronged outside. Many grumbled about being excluded from deliberations on an issue of intense interest. But staff aides said the markup was moved to allow members to be near the Senate floor for a series of votes on the budget.

By Alissa J. Rubin

The Lines Are Drawn

The dynamics have changed this year because Nancy Landon Kassebaum, R-Kan., an abortion rights supporter, has replaced abortion rights opponent Orrin G. Hatch, R-Utah, as the committee's ranking minority member.

In an opening statement, Kassebaum spoke calmly about the emotional issue, framing herself as a moderate while acknowledging that no middle ground will satisfy both sides.

"At the heart of the issue is whether one believes abortion should be legal. I do," Kassebaum said. "What most of us find troubling is that lines get drawn in the sand and neither side will move. I don't know that there can be a compromise on this."

Moments later, Tom Harkin, D-Iowa, and Daniel R. Coats, R-Ind., got into a sharp disagreement that seemed to illustrate her point. Harkin is a strong supporter of abortion rights; Coats opposes abortion.

"We wouldn't be here if women represented half the Supreme Court," Harkin said. "Abortions do not happen to men, they happen to women."

"And children," Coats said softly.

"It happens to women," Harkin said.

"Children," Coats insisted.

"Women," Harkin said a little louder.

"Children and fetuses," said Coats.

Coats then offered an amendment that would make an abortion performed in the ninth month of pregnancy exempt from the protections of the abortion rights bill. He later withdrew it.

Three Emerging Factions

In committee discussion, three factions emerged: those who support the current bill, which would put very few limits on abortion rights; those who oppose abortion and seek to place as many limits on it as possible; and those who seek a middle ground.

Members voted on no amendments at the markup, but several lawmakers said they voted for the bill only to move it to the floor, where they could get a full Senate vote on their amendments.

Kassebaum said that when the bill reaches the floor, she will propose a package of amendments that would codify several aspects of the U.S. Su-

BOXSCORE

Bills: S 25; HR 25 — Abortion rights act.

Latest action: Approved 12-5 on March 24 by Senate Labor and Human Resources Committee.

Next likely action: Senate floor about May 1. House Judiciary Committee by the end of April.

Background: The bill would explicitly establish a woman's right to obtain an abortion.

Reference: Weekly Report, pp. 675, 182.

preme Court's 1992 decision in *Planned Parenthood of Southeastern Pennsylvania v. Casey.*

In that case, the court ruled that abortion is a protected right but that states have some leeway to limit the circumstances under which a woman may have an abortion. Specifically, the justices upheld a 24-hour waiting period before a woman can obtain an abortion, mandatory counseling based on state-prepared materials and parental consent for teenagers.

Kassebaum said she would support a 24-hour waiting period but would want the clock to start ticking when the woman made the appointment, not when she arrived at the clinic.

Kassebaum also would require that a woman be offered information about the age of her fetus and other options besides abortion. Kassebaum said she wants state parental involvement laws to conform with the Supreme Court's 1979 decision in *Bellotti v. Baird.* That ruling said that if a state requires parental involvement, it also has to allow a judicial bypass so that minors who cannot talk to their parents can get permission for an abortion from a judge or other adult — such as a social worker.

Harris Wofford, D-Pa., also said he wanted to codify aspects of the *Casey* decision but did not say whether he would support Kassebaum's amendments.

Senate-House Differences

The Senate bill differs in three ways from the 26-line House bill:

- It allows states to refuse to use Medicaid dollars to pay for abortions for poor women. The House bill is silent on public funding of abortion.
- It explicitly allows states to enact parental consent or notice laws for teenagers.
- It allows private health-care institutions that are morally opposed to abortion, such as Catholic hospitals, to refuse to perform them. The House bill allows only individuals — not institutions — to decline to perform abortions for reasons of conscience.

Abortion rights advocates object to the Senate's conscience clause because they say that any hospital — not just those with religious affiliations — could refuse to perform them. That could make it difficult for women in remote areas to obtain an abortion, they say.

The House Judiciary Subcommittee on Civil and Constitutional Rights approved similar legislation (HR 25) on March 18. *(Weekly Report, p. 675)*

House Passes Family Planning Bill That Allows Abortion Referrals

After 10 years of fighting a losing battle with the Republican administration over family planning legislation, the House passed a family planning bill March 25 that the Senate is likely to adopt and that President Clinton has pledged to sign.

The bill (HR 670) would authorize funding for the nation's 4,000 family planning clinics and allow them to refer clients for abortions.

The House voted 273-149 to authorize the program for two years, increase clinic funding to $238 million in fiscal 1994 and codify Clinton's Jan. 22 executive order suspending the Bush administration's ban on abortion counseling at federally funded clinics. *(Vote 107, p. 792)*

The House debate March 24 and March 25 gave the first sign of members' views on a key question that will come up on a pending bill (HR 25) that would explicitly establish a woman's right to an abortion: Should the federal government decide whether parents should be involved in their underage daughter's decision to have an abortion? The House has never voted on parental involvement laws.

In a victory for the Clinton administration and sponsors of HR 25, known as the Freedom of Choice Act, the House rejected 179-243 a motion that would have put in place a restrictive federal parental notice law for those family planning clinics affiliated with nearby abortion facilities. *(Vote 106, p. 792)*

The vote, however, seemed to be less about parental involvement and more about whether such involvement should be mandated by states or the federal government. Many who rejected federal involvement said they were strong supporters of state parental notice or consent laws.

The relatively strong support for the bill led Henry A. Waxman, D-Calif., to conclude that the abortion issue "had less sting" this year.

But anti-abortion lawmakers said that passing the abortion rights bill would not be so easy. Thomas J. Bliley Jr., R-Va., who opposes abortion and sponsored the parental notice amendment, pledged to bring it or a similar measure back when HR 25 is considered.

BOXSCORE

Bill: HR 670 — Renewal of federally funded family planning clinics.

Latest action: Passed by the House, 273-149, on March 25.

Next likely action: Senate course uncertain.

Background: President Bush vetoed the 1992 bill over language that would have lifted the ban on abortion counseling.

Reference: Weekly Report, pp. 393, 270; 1992 Weekly Report, pp. 3475, 3049.

Much of the debate on the family planning bill consisted of a series of parliamentary maneuvers by Democrats, leading to a growing discord over their use of the rules to keep Republican amendments from reaching the floor.

Rules for debate were first drafted in February, with floor debate scheduled for Feb. 18. But when House leaders realized that many freshmen were confused about how some amendments worked, they pulled the bill. *(Weekly Report, p. 393)*

This time, instead of adopting the February rule, the Rules Committee allowed lawmakers to file amendments again. But for every Republican amendment, the Democrats filed a second-degree amendment (an amendment to the amendment). Under House rules, those superseded the Republican versions, effectively precluding a vote on the original Republican amendments.

That meant, for instance, that the House never voted on an amendment by Tom DeLay, R-Texas, that would have required that family planning counselors have degrees in medicine, psychology or nursing.

Instead, the House voted on DeLay's amendment as modified by Waxman. Waxman added to the list of approved counselors anyone approved by the secretary of Health and Human Services or anyone allowed to provide counseling under state law. *(Votes 96 and 103, pp. 788, 790)*

April 26, 1993

TO: Mandy Grundwald

FROM: Linda Bergthold

RE: The Relation of Abortion Coverage to Existing State Laws on Parental Notification, etc.

Per your question to me outside Ira's office this morning: By including abortion coverage under "pregnancy related care," abortion services can continue to be provided as they are in the majority of private plans today. (Our best estimates are that 80% of private plans cover abortion, either explicitly or implicitly.) Abortion would not be restricted outside the scope of Roe v. Wade or according to State laws regulating abortion. The womens' groups have agreed that abortion would, however, continue to be subject to State provisions such as parental notification, waiting periods, conscience clause, etc. as found constitutional by the Supreme Court. States would not be permitted to deny coverage of the benefit.

We are currently working on a new definition of "medical appropriateness" that we believe may provide a better way to judge the inclusion of services than the existing "medically necessary and/or appropriate" language. Would you like to be kept in the loop on this?

April 22, 1993

MEMORANDUM

TO: Melanne Verveer
Mandy Grundwald

FROM: Linda Bergthold

RE: **ABORTION COVERAGE IN PRIVATE PLANS**

Attached is the information you requested on states that restrict abortion coverage in private insurance plans. I have also attached a description of state laws that restrict abortion coverage for state employees.

What restrictions are placed on abortion in private plans?

There are five states that limit or prohibit the coverage of abortion in private plans. All but Pennsylvania allow a separate rider to be sold for coverage of abortions under specific circumstances. The restrictions in Missouri and Rhode Island were both challenged in court. The Rhode Island limitation was ruled unconstitutional. The Missouri limitation was upheld. Neither case was heard by the Supreme Court.

What restrictions are placed on abortion for state employees?

Five states (including Pennsylvania which also restricts private plans) restrict abortion coverage in insurance plans offered to state employees. These restrictions generally invoke state prohibitions on the use of public funds for abortion coverage.

How many private plans cover abortion?

We have thorougly researched this issue and cannot provide you with reliable numbers on the proportion of all private insurance plans that cover abortion. However, in conversations with legal scholars, private insurers, and large self-insured employers, I am told that **most private insurance plans cover abortion implicitly,** unless a company specifically requests the insurance company to exclude abortion.

How much does it cost to cover abortion in private plans?
The cost of abortion is a negligible factor in the premium and most companies cannot even quantify it, because the cost of this service is calculated as the **risk of pregnancy if taken to term, not the cost of an abortion.** Insurance underwriters regard the inclusion of abortion as a way to limit overall costs.

STATE LAWS RESTRICTING ABORTION COVERAGE IN INSURANCE PLANS FOR STATE EMPLOYEES

Five states (Colorado, Illinois, Massachusetts, Nebraska, and Pennsylvania) have laws that restrict abortion coverage in insurance plans for state employees. These state mandates, along with hundreds of others, will be preempted by federal health care reform legislation.

Colorado -- The Attorney General has issued an opinion stating that group health insurance provided by the state for its employees must exclude coverage for abortions in accordance with the state constitution's prohibition on the use of state funds for abortions. 1985 Colo. AG LEXIS 28 (Feb.6, 1985); Colo. Const. art. V, sec. 50 (amended 1985).

Illinois -- Group health insurance for state employees must exclude coverage for abortions unless necessary to preserve the life of the woman. Health benefits for abortion may be available on an optional basis through an HMO if a premium for such coverage is paid by the member. Ch. 127, ¶¶ 526, 526.1.

Massachusetts -- Health insurance paid for by the state or a subdivision thereof for government employees and retirees (and their dependents) may not provide coverage for abortion unless the abortion is found by a panel of qualified physicians to be necessary to prevent the death of the woman. Ch. 32A, Sections 4, 10B, 10C, 12, 14; Ch. 32B, Sections 3, 3A, 11C, 16.

Nebraska -- No group insurance contract or HMO agreement paid for in part with public funds may include coverage for abortion not necessary to prevent the woman's death. Section 44-1615-01.

Pennsylvania -- No health plan for employees, funded with any Commonwealth funds, shall include coverage for abortions unless an independent physician certifies that an abortion is necessary to avert the death of the woman or unless the pregnancy is the result of reported rape or incest. Title 18, Section 3215(D)

STATE LAWS RESTRICTING ABORTION COVERAGE IN PRIVATE INSURANCE

Six states (Idaho, Kentucky, Missouri, North Dakota, Pennsylvania, and Rhode Island) have passed laws that restrict abortion coverage in private insurance plans. One state's law (Rhode Island) has been ruled unconstitutional and is not in effect. These state mandates, along with hundreds of others, will be preempted by federal health care reform legislation.

Idaho (*) -- Disability insurance policies, individual insurance policies, and HMO policies must exclude coverage for abortions not necessary to preserve the woman's life. Coverage for other abortions may be obtained only if the insurance company elects to offer it and a separate premium is paid. Sections 41-2142, 41-2210A, 41-3439, 41-3934.

Kentucky (*) -- No health insurance contracts, plans, or policies can provide coverage for abortions not necessary to preserve the woman's life unless an optional rider is obtained and a separate premium is paid. This provision applies to plans offered by insurance companies, HMOs, self-insured employers. Section 304.5-160.

Missouri (*) -- No health insurance contracts, plans, or policies can provide coverage for abortions other than spontaneous abortions or abortions necessary to prevent the death of the woman unless an optional rider is obtained and a separate premium is paid. Section 376.805.

North Dakota -- No health insurance contracts, plans, or policies can provide coverage for abortions other than abortions necessary to prevent the death of the woman unless an optional rider is obtained and a separate premium is paid. Section 14-02.3-03.

Pennsylvania -- All insurers who make available health care and disability insurance must offer policies that contain an express exclusion for abortion services not necessary to avert the death of the woman or to terminate pregnancies caused by rape or incest. Title 18, Section 3215(E).

Rhode Island -- All health insurance contracts, plans, and policies must exclude coverage for abortion unless the abortion is necessary to preserve the woman's life or resulted from rape or incest unless an optional rider is obtained and an additional premium is paid. Sections 27-18-28, 36-12-2.1 (This law has been ruled unconstitutional.)

(*) These statutes use the term "elective" abortions, defined as any abortion for any reason other than to preserve the woman's life.

USCC 6/1

20 Neg dramatic happened, perceived difficulties of adm - embodied in critics.

Bishops Discuss a Health-Care Stance on Abortion

By PETER STEINFELS

The nation's Roman Catholic archbishops held a private meeting in Chicago yesterday to discuss what stance they will take toward a national health-care plan if it covers abortions.

Church officials described the meeting as preliminary to a full discussion of the issue when all the nation's bishops hold their regular spring meeting in New Orleans on June 17-19.

But the secrecy surrounding yesterday's gathering seemed to indicate that church leaders were having difficulty with a question that poses political perils and also challenges their moral principles. The archbishops are the leading prelates in the 33 regions into which the American church's 162 dioceses are organized. There were joined by representatives of the Catholic Health Association, Catholic Charities and state Catholic conferences.

The bishops have long advocated major changes in the nation's health-care system. In early April, Bishop John H. Ricard, an auxiliary bishop from Baltimore who is the chairman of the bishops' committee on domestic policy, wrote to Hillary Rodham Clinton, the head of the President's Task Force on Health Care Reform, to urge "true universal access and rapid steps to improve the health care of the poor and unserved."

2-Pronged Message

But Bishop Ricard also warned Mrs. Clinton that including abortion coverage in a health-care plan would be "a moral tragedy, a serious policy misjudgment and a major political mistake."

On April 29, a delegation of church leaders, led by James Cardinal Hickey of Washington, met with Mrs. Clinton for more than an hour and delivered a similar two-pronged message.

During the campaign, President Clinton said abortion coverage would be included in his overhaul of the health-care system, a position later echoed by the Secretary of Health and Human Services, Donna E. Shalala. But Administration officials have generally spoken of covering reproductive health services without singling out abortion as something that would or would not be included.

Mr. Clinton's task force is expected to unveil proposals for overhauling the health system next month, then present them to Congress. One part of the plan is expected to be a standard package of benefits that must be offered by all health insurance plans. While hospitals would probably have to be affiliated with at least one insurance plan, each hospital might not have to offer every service the plan would be required to provide.

Large Presence in Health Care

About 10 percent of the nation's hospitals, totaling about 15 percent of all hospital beds, are operated under Catholic auspices. In 1992, they treated almost 56 million people, according to the Catholic Health Association.

In an April article reporting that yesterday's meeting had been scheduled, Catholic Insight, a newsletter published by the moderately conservative Our Sunday Visitor Press, stated, "The hush-hush meeting in Chicago signals that a longtime nightmare of the bishops and their Washington-based staff is well on its way to becoming a reality: a comprehensive health-care proposal that has a chance of passage which includes abortion."

The bishops are torn between mounting a blanket opposition to such a proposal, bargaining for a version that at least minimizes their moral concerns or withdrawing from the public debate.

Clash of Moral Principles

Opposition to Government-financed abortion still runs strong in Congress. In tandem with other roadblocks that any overhaul of the health-care system will inevitably encounter, opposition from the bishops and Catholic health-care providers could kill the legislation.

The bishops fear that their opposition may hurt support for their anti-abortion case among Catholic voters as well as among the many Americans with mixed feelings about abortion whom the bishops would like to draw into an anti-abortion coalition.

But the bishops are also determined not to compromise the church's teaching that abortion is an unjustified taking of human life. Anything resembling compromise will provoke loud protests from Catholic anti-abortion groups and their allies in the hierarchy.

To many of these groups, offering qualified support for a health-care plan that includes abortion coverage would betray moral principle, even if the plan protected Catholic hospitals from having to provide abortions.

- little to stop
- committed to health reform
- knock abortion out Hyde ☐ test
- possible if don't prevail cross more bridge when get to it.
- don't participate in defeating health care or give up abortion
- in June pro vs. life etc.

(1) Recapture - basics health & women some fashion

(2) elected - abortion or Medicaid (state decision or priv sector)

(3) supplemental -

(4) conscience clause

(5) indiv'l conscience clause / docs, nurses, employers.

8

Panel Eases Employers' Tax on Domestic Workers

By MICHAEL WINES
Special to The New York Times

WASHINGTON, May 11 — The House Ways and Means Committee today kicked off the prickly task of writing President Clinton's economic program into law by giving some taxpayers a break: it voted to raise sharply, to $1,750 a year, the $50-a-quarter threshold that an employer can pay a domestic worker before becoming liable for Social Security taxes.

That was a belated bow to Zoë Baird, the wealthy Connecticut lawyer whom Mr. Clinton dropped as his choice for Attorney General after it was found that she had failed to pay taxes on the earnings of her chauffeur and nanny. The Internal Revenue Service says the changes approved today, if adopted into law, would benefit far more than the rich, affecting three million or more Americans who hire cooks, maids, sitters, gardeners and other household help.

It was, nevertheless, a thimbleful of sugar in what promises to be an ocean of medicine. By the time the panel finishes drafting Mr. Clinton's program into bill form, probably late this week, it will almost certainly have approved plans for some $300 billion in new or higher taxes on income, energy and business earnings

The domestic-worker rule, and the approval later of plans to spend more on child welfare, were the notable achievements of a day spent mostly on rote work and political labors.

'Supportive of the President'

The panel's chairman, Representative Dan Rostenkowski of Illinois, spent most of the afternoon with his committee's 23 Democrats, lining up support for the more dicey tax measures that he must steer past the Republican minority later in the week. The 14 Republicans, who will have virtually no say in the outcome, spent the afternoon plotting ways to frustrate him.

After the Democrats had met for several hours, Mr. Rostenkowski said, "To an individual, they want to be supportive of the President."

Other Democrats said that the essence of the Clinton tax plan — higher tax rates on the wealthy, a new tax on fuel, taxes on more of the Social Security benefits of middle- and upper-income retirees and a big expansion of tax credits for the working poor — would be approved. But they said some changes would be made on the edges.

The biggest debates, they said, were over how to reallocate the $30 billion that Mr. Clinton originally wanted for an investment tax credit to business and how to craft the fuel tax proposal in a way that would generate the most possible political support.

Corporate Tax Rate Question

Mr. Rostenkowski said he would like to hold the corporate tax rate at no higher than 35 percent, but was not certain that could be accomplished. The rate is now 34 percent, and Mr. Clinton wants it raised to 36 percent.

Although the panel is working mostly on tax-code changes, lawmakers devoted most of their time today to a grab-bag of economic and trade issues that are also in the bill. Among the actions the panel took were these:

¶It approved an Administration initiative to reduce the flood of children into foster homes by spending more to counsel troubled families and address child neglect and abuse. The $1.5 billion program is offset in part by $1.3 billion in spending cuts in other programs.

¶It agreed to postpone for a year the effective date of a law passed under President Ronald Reagan that would require states to find jobs or job training for tens of thousands of married welfare recipients. The Clinton Administration asked for a two-year postponement, contending that the welfare rolls would be pared more effectively if programs concentrated on finding jobs for single mothers.

¶It adopted an amendment by Representative Charles B. Rangel, a Manhattan Democrat, that would extend through 1998 a trial program in New York State that tries to keep families off welfare by increasing child-support collections.

A House bow to the issue raised by Zoë Baird.

Simplifying the Process

Today's action on domestic workers, if enacted, promises to vastly simplify the process of paying all taxes, state and Federal, on the household help now employed by at least three million American families.

The current law requires employers to pay Social Security taxes on any domestic worker who is paid more than $50 in a three-month period, a figure that has not been adjusted since the law was passed in 1950. Critics say that if it were taken literally, millions of taxpayers would have to file quarterly returns to cover taxes on teen-agers who mow their lawns or baby-sit.

The Internal Revenue Service says that 733,000 employers do file such quarterly returns on their household workers, but that about 2.2 million other employers are probably dodging the law, either from ignorance or confidence that they will not be caught.

The changes adopted by the Ways and Means Committee, on a voice vote, raise the $50-a-quarter threshold to $1,750 a year this year and $1,800 in 1994, with adjustments for inflation thereafter. Employers paying less than that would not be required to pay any Social Security taxes on their workers.

The $1,750 figure, aides said, roughly accounts for the effect of inflation in the 43 years since the law was passed. In a gesture to employers who have avoided the tax and are either caught or decide to make amends, the committee voted to apply the threshold retroactively, adjusted for inflation, back to 1950.

The effect would be to encourage compliance with the law by reducing or eliminating the liability of many who have been evading it.

While the changes benefit employers, they are potentially less helpful to the domestic workers themselves, who could find it harder to gain eligibility for Social Security or see their retirement benefits reduced.

Under the law, workers receive credit for three months worked every time they earn $560, up to four times a year. The law requires at least 40 such quarters over a life's work before a worker can become eligible for retirement or disability benefits.

Under the new reporting requirements, the I.R.S. estimates, 16 percent of the nation's domestics would lose at least one quarter of earnings credit because they fall beneath the new reporting threshold, thus lowering the odds that they could reach the 40-quarter goal.

Other amendments adopted today could wipe out much of the paperwork for employers, who now must pay Social Security and state and Federal unemployment taxes each quarter.

The changes would permit employers to pay Social Security obligations on household help each April 15, as part of their annual 1040 tax filing, and to avoid paying a lump sum by having the taxes deducted from their paychecks. It would allow the same arrangement for paying Federal unemployment taxes, which are required for any domestic earning more than $1,000 a quarter.

9

Choice Issues
May 14, 1993

1. **Appropriations** (see Attachment A)

   - o Labor-HHS Gen. Provisions Sec. 203
   - o D.C. Appropriations
   - o State-Commerce-Justice Gen. Provisions Secs 103, 104, 105
   - o Treasury-Post Office Appropriations, Secs 513, 514 of Title V
   - o DOD-USC, Sec. 1093 of Title 10
   - o Foreign Aid--H.R. 5368 Foreign Operations, PL 102-391, Secs 524, 534

2. **Freedom of Choice Act**

   - o House/Senate differences
   - o timing

3. **Other choice-related bills introduced in this Congress** (see Attachment B)

4. **Health care**

   - o content of basic benefits package

5. **Supreme Court nomination**

6. **Other legislative or policy issues**

   - o **Family Planning Amendments of 1993 (Senate version)**
   - o RU 486
   - o Casey challenge
   - o other?

Attachment A

ABORTION-RELATED GENERAL PROVISIONS

Appropriation Bill	Current Status	Affected Population
Labor-HHS General Provisions Sec. 103	Federal funding allowed only when the life of the mother is endangered if the fetus is carried to term.	Medicaid, Indian Health Service, and PHS grantee clients
D.C. Appropriation Bill	Funding allowed only when the life of the mother in endangered if the fetus is carried to term. (Includes local tax funds).	D.C. residents who would otherwise receive non-Medicaid funding for abortions
State-Commerce-Justice General Provisions Sec. 103, 104, 105	Federal funding allowed only when the life of the mother is endangered if the fetus is carried to term. Also provides that "no funds shall be used to require any person to perform or facilitate an abortion; " but permits funds for escorting to abortion services outside the Bureau of Prisons.	INS detainees, sentenced and pre-sentenced prisoners, transitionally housed asylees, special witnesses and families protected by DOJ, and inmates
Treasury-Post Office appropriation bill, Sec. 513, 514 of Title 5	FEHB plans may not cover abortions unless the mother is endangered if the fetus is carried to term.	Federal employees and dependents
DOD-United States Code, Sec. 1093 of Title 10,	Federal funding allowed only when the life of the mother is endangered if the fetus is carried to term.	Military personnel and dependents
Foreign Aid--H.R. 5368 Foreign Operations, PL 102-391, Sec 524 and 534 (Kemp-Kasten Amendment)	No funds shall be used for : 1) abortions, 2) to lobby for abortion, or 3) involuntary sterilization as a method of family planning or as incentive to undergo sterilization.	Peace Corps workers and countries receiving U.S. foreign assistance

Attachment B

---

31 bills found -- On the subject of Abortion

Bills 1-11 of 31 Screen 1 of 3

H.R. 4 by WAXMAN (D-CA) -- National Institutes of Health Revitalization Act of 1993 [3,716 lines] (OVERTAKEN BY S. 1)
* H.R. 25 by EDWARDS, DON (D-CA) -- Freedom of Choice Act of 1993 [81 lines]
H.R. 26 by FAZIO (D-CA) -- Reproductive Health Equity Act [138 lines]
* H.R. 129 by COLLINS, CARDISS (D-IL) -- Adolescent Health Demonstration Projects, Provision [71 lines]
H.R. 178 by EMERSON (R-MO) -- Use of Federal Funds for Abortions, Provision [37 lines]
H.R. 437 by WYDEN (D-OR) -- Antiprogestin Testing Act of 1993 [47 lines]
H.R. 519 by LOWEY (D-NY) -- Reproductive Freedom Protection Act [57 lines]
H.R. 562 by DORNAN, ROBERT (R-CA) -- Internal Revenue Code of 1986, Amendment [39 lines]
* H.R. 670 by WAXMAN (D-CA) -- Family Planning Amendments Act of 1993 [129 lines] (HOUSE HAS PASSED; SENATE VOTE PRIOR TO FINAL LAW)
* H.R. 796 by SCHUMER (D-NY) -- Freedom of Access to Clinic Entrances Act of 1993 [90 lines]
* H.R. 1068 by TORKILDSEN (R-MA) -- Freedom of Choice Act of 1993 [102 lines]

---

* There has been some action (e.g., hearings, subcommittee markup, etc.) on the bill.

List of Bills Found
Bills 12-20 of 31 Screen 2 of 3

H.R. 1175 by OBEY (D-WI) -- Research on Human Fetal Tissue Amendments of 1993 [182 lines]
H.R. 1991 by SMITH, CHRISTOPHER (R-NJ) -- Most-Favored-Nation Treatment for China, Provision [358 lines]
H.Res. 81 by SLAUGHTER, LOUISE (D-NY) -- Procedural Resolution - H.R. 670 [57 lines]
H.Res. 138 by SLAUGHTER, LOUISE (D-NY) -- Procedural Resolution - H.R. 670 [37 lines]
H.Con.Res. 22 by SCHROEDER (D-CO) -- Resolution Concerning Contraception and Infertility [95 lines]
H.Con.Res. 40 by DELAY (R-TX) -- Resolution Opposing the Imposition of a Sexual Agenda on Children [49 lines]
H.J.Res. 26 by EMERSON (R-MO) -- Constitution of the United States, Amendment - Right to Life [43 lines]
H.J.Res. 128 by OBERSTAR (D-MN) -- Constitution of the United States, Amendment - Right to Life [45 lines]
H.J.Res. 158 by DORNAN, ROBERT (R-CA) -- Constitution of the United States,

---

List of Bills Found
Bills 21-31 of 31

Amendment - Right to Life [48 lines]
H.J.Res. 176 by MINK (D-HI) -- Constitution of the United States, Amendment - Reproductive Rights [34 lines]
* S. 1 by KENNEDY, EDWARD (D-MA) -- National Institutes of Health Revitalization Act of 1993 [3,791 lines] VOTE ON CONFERENCE REPO EXPECTED NEXT WE
* S. 25 by MITCHELL, GEORGE (D-ME) -- Freedom of Choice Act of 1993 [115 lines]
S. 40 by HELMS (R-NC) -- Civil Rights of Infants Act [47 lines]
S. 48 by HELMS (R-NC) -- Unborn Children's Civil Rights Act [97 lines]
S. 60 by HELMS (R-NC) -- Civil Rights of Infants Act [44 lines]
S. 64 by HELMS (R-NC) -- Unborn Children's Civil Rights Act [94 lines]
S. 222 by WELLSTONE (D-MN) -- Antiprogestin Testing Act of 1993 [115 lines]
S. 337 by BINGAMAN (D-NM) -- Ethics in Referrals and Billing Act [731 lines]

* S. 636 by KENNEDY, EDWARD (D-MA) -- Freedom of Access to Clinic Entrances Act of 1993 [231 lines]
S.Res. 90 by DURENBERGER (R-MN) -- Resolution Concerning the First Amendment to the Constitution [43 lines]

---

receiving the medal, but a lot of 18 and 19-year-old men and women in uniform who demonstrated enormous discipline, good judgment and a good deal of patience in performing a rather unique mission. I don't think that any other country in the world could have done what we did to have led this coalition. And I saw it in the response of Somalis who, when they saw an American in the Chocolate Chip, would give you this sign or this sign and say "American." It is a good feeling to be an American, to be wearing this uniform, and very importantly, to be back in the United States.

And thank you all for your great support over these past five months. And especially my thanks to the President of the United States, our Commander-in-Chief, for giving us such a warm welcome home. Thank you very much. (Applause.)

END 10:47 A.M. EDT

FOCA - pending floor - S
pending Brooks Comm. H.
"our initiative"

Casey standard raised
States moving to adopt Casey
Legal - strongest.

S - 60 votes + amendments
- Congress asked to pull back + wait.
"Adam line"
Want to protect abort - leave it to State
Leadership in House: "No"
Go to H. first!

(Brooks waiting to hearing)

(2) Appropriations (None can offer abortion services
(1st) Treas., etc - Fed. employees.

(Budget have a footnote)?

> Conversation Comm. clear - this can offer abortion coverage -
+ need amendment to delete "(Defend States Guo))

(2nd) - HHS - (Fight for closed Rule)
Footnote definition

"Denying what's medically necessary"

Maintain States Guo in states?
only 13 States fund.

In H - no amendment rule but get rid of footnote.
In Medicaid Statute - "medically necessary":
most states freed to change
who "decides"?
< poor woman can have baby under Medicaid, not abortion

THE WHITE HOUSE

WASHINGTON

TO: Howard Paster
George Stephanopoulos
Rahm Emanuel
Alexis Herman
Bernie Nussbaum
Christine Varney
Melanne Verveer

FROM: Carol H. Rasco

SUBJ: Abortion policy

DATE: May 10, 1993

Because of the various votes that we will face in the coming months on abortion and choice issues, it is important that we come together and try to articulate a plan for the President to review. I have asked Bill Galston of my staff to convene a working group with you and/or representatives of your departments to serve as an ongoing coordinating point for this matter within the White House.

Please let Rosalyn Kelly in Domestic Policy know by the close of business Thursday, May 13 the name(s) of the person(s) in your department to be notified for a first meeting early next week.

Thank you.

cc: Bill Galston
Rosalyn Kelly

THE WHITE HOUSE

WASHINGTON

May 10, 1993

MEMORANDUM FOR SUSAN BROPHY
RAHM EMANUEL
ALEXIS HERMAN
LORRAINE MILLER
BERNIE NUSSBAUM
CAROL RASCO
STEVE RICCHETTI
RIKKI SEIDMAN
GEORGE STEPHANOPOULOS
CHRISTINE VARNEY
MELANNE VERVEER

FROM: HOWARD PASTER HP

SUBJECT: ATTACHED DRAFT MEMORANDUM FOR THE PRESIDENT

I would welcome any comments you have on the attached draft memorandum by close of business Tuesday, May 11.

D R A F T

INFORMATION

MEMORANDUM FOR THE PRESIDENT

FROM: HOWARD PASTER

SUBJECT: FREEDOM OF CHOICE LOBBY AND THE LEGISLATIVE CALENDAR

We are coming under increased pressure from the Freedom of Choice lobby to press Speaker Foley and Majority Leaders Gephardt and Mitchell to take up the Freedom of Choice Act as early as next month. In deciding how to respond to that request, it is necessary to take a look at how the broader issues of abortion and choice will play out during the balance of the year.

It is likely that abortion-related debates and votes will develop in the House and/or the Senate on four separate appropriations bills:

- The Labor-HHS appropriations from which you have deleted the Hyde amendment and where there will certainly be a battle about the appropriate use of federal funds to finance abortions;

- The Treasury, Post Office, General Government appropriations from which you have deleted a provision that precluded health plans for federal employees from including abortion as an available benefit in such plans;

- The Defense appropriations where there is often a debate on the terms and conditions under which abortions may be performed in military hospitals; and

- The District of Columbia appropriations which President Bush vetoed because it did not limit abortion rights in the District despite the federal payment to the District.

In addition, the foreign aid bill may engender additional debate because of policy changes you have made in this area.

Also, however abortion rights are dealt with in the health care reform initiative, we know in advance there will be an intense debate on this question. Already we have health care reform allies weighing in passionately on both sides of the issue. This debate will take place in several committees throughout the hearing and mark-up process and on the floor for the balance of 1993.

In the face of all of this we are confronted with intense and growing pressure from Clinton supporters who maintain the Freedom of Choice Act (FOCA) was not taken up last year as a courtesy to the Clinton campaign. The argument being made is quite simple: you told us last fall it was a bad time to have FOCA debated in the House and Senate and we accepted your recommendation in order to help elect a pro-choice ticket. Now you owe it to us to encourage the Hill leadership to move the bill quickly. If you do not help us press for quick action on this most fundamental measure, we will then wonder what is the value of having helped to elect a pro-choice ticket.

The counter argument, made by some, is that it is not in the interests of the Administration to have a substantial national debate on abortion at a time when we want to refocus attention on the economy and health care reform. Those who hold this point of view argue that we will have a good many abortion debates and votes in the months ahead; it does not make sense for us to unnecessarily bring attention to this issue. In the words of one Member of Congress with whom I spoke, "This, along with gays in the military, will worsen your cultural disconnection with urban, ethnic, and other swing voters."

While not directly related, there is nonetheless a connection between this issue and your selection of a nominee for the Supreme Court. If you do not nominate a woman it will probably further complicate the gender politics raised by the choice advocates. There will likely be even more agitation if you nominate a man whose choice position is not clear.

While this memo -- which I showed in draft form to a number of senior staff -- is not designed to elicit a decision, I hope this background will help should you be confronted with a question on this issue before a firm policy is determined. Also, I will seek to have this memo serve as the catalyst for a staff process that will bring a more carefully delineated set of options to you.

cc: Melanne

RUSSELL D. FEINGOLD
WISCONSIN

United States Senate

WASHINGTON, DC 20510-4904

April 20, 1993

First Lady Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mrs. Clinton,

We understand that you recently met with a number of women members of the House and Senate who expressed their strong concern that the health care reform proposal being developed by your task force include reproductive health care services, including family planning and abortion services, in the basic benefit package.

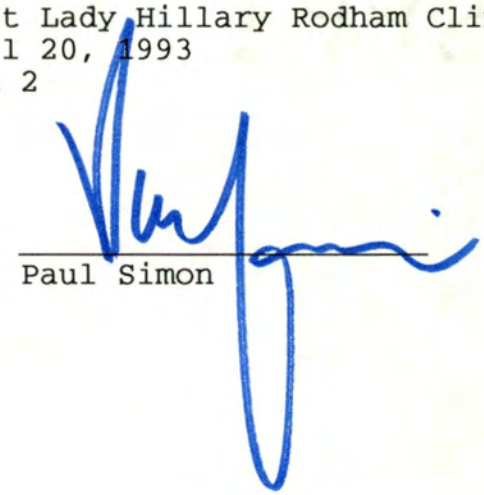
We are writing to let you know that we share those concerns and believe that it is vitally important that any new national health care plan provides all women the right to make reproductive health care choices, including abortion, with their physicians free from government intrusion. Comprehensive reproductive health care is an essential component of primary care for women. It is thus critical that any new national health care plan guarantees women access to and coverage for all reproductive health care services, including abortion services. Failure to include abortion services in the basic benefit package would be a serious setback in the effort to protect the rights of every woman to make her own reproductive choices and to ensure that all Americans have adequate access to health care services.

We urge you to include coverage of abortion services in the comprehensive benefits package which is now being formulated and we pledge to work with you to help ensure that the full range of reproductive health services remains part of any health care reform measure.

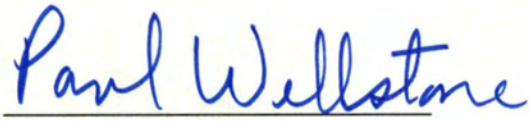
Sincerely,

Russ Feingold
Russell D. Feingold

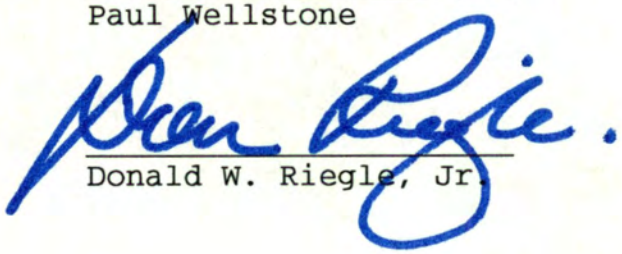
Howard M. Metzenbaum



Paul Simon



Paul Wellstone



Donald W. Riegle, Jr.

The Washington Post

AN INDEPENDENT NEWSPAPER

Abortion and Medical Coverage

THERE ARE obvious reasons to support the president's decision to include abortion in the soon-to-be-proposed health care reform legislation. The procedure is part of a package of reproductive medical services, along with contraceptive, prenatal and maternity care. In a number of states, particularly the large ones, it is included under the Medicaid program. Abortion has, in the past, been part of the health insurance packages available to federal employees—though the benefit has been temporarily suspended—and probably will be made available again soon. Most private health insurance plans include abortion services, and so should any national program.

To leave abortion coverage out of any new system would further isolate the professionals who provide the service. It is already difficult to find doctors who are trained to perform abortions and willing, in the face of hostility that is often extreme, to do so. Most counties in the United States have no providers, and some states are covered by only one or two physicians willing to undertake this task. Perhaps abortion opponents see exclusion as a way to marginalize these service providers and foster the image of abortion as a shameful, not quite legitimate procedure. If so, they should not be allowed to succeed.

Some organizations and individuals who oppose abortion on moral grounds want it eliminated from the national package. The Catholic Church, for example, which sponsors the nation's largest network of nonprofit hospitals and nursing homes, is an important player in formulating national health policy. It would be a blow if the church's support for reform dissolved because of this issue. It is almost certain that the president's package will contain a conscience clause so that hospitals and health care professionals with objections to abortion will not have to perform them. That should protect opponents without depriving others, and that should be enough.

The federal government does not contribute its share to states providing abortions to the poor through Medicaid. President Clinton has, to his credit, set out to change that policy. Coverage should not be excluded from the landmark legislation now being prepared, which will cover the entire population.

42

Gays in the Military: The Nunn Hearings

What emerges from the Sam Nunn hearings on gays in the armed forces [front page, May 12] is that leadership by the nation's military is falling victim to rank prejudice.

The failure of Gen. Colin Powell to do anything more than re-state archaic views of homosexuals was echoed by Gen. Norman Schwarzkopf. It appeared again, sadly, in the case of Col. Fred Peck, who—while saying he loved his gay son—endorsed limiting his son's choices. The fact that Col. Peck feared for his son's safety was commendable, but a leader would have sought to educate and change the prejudicial views that would threaten his son rather than yield to them.

Only President Clinton has shown leadership in this touchy matter. When I was at Virginia Military Institute, there was a motto at the entrance of the barracks, which stated: "You May Be Whatever You Resolve To Be." To that inscription from Stonewall Jackson, these men are adding: "unless you're gay!"

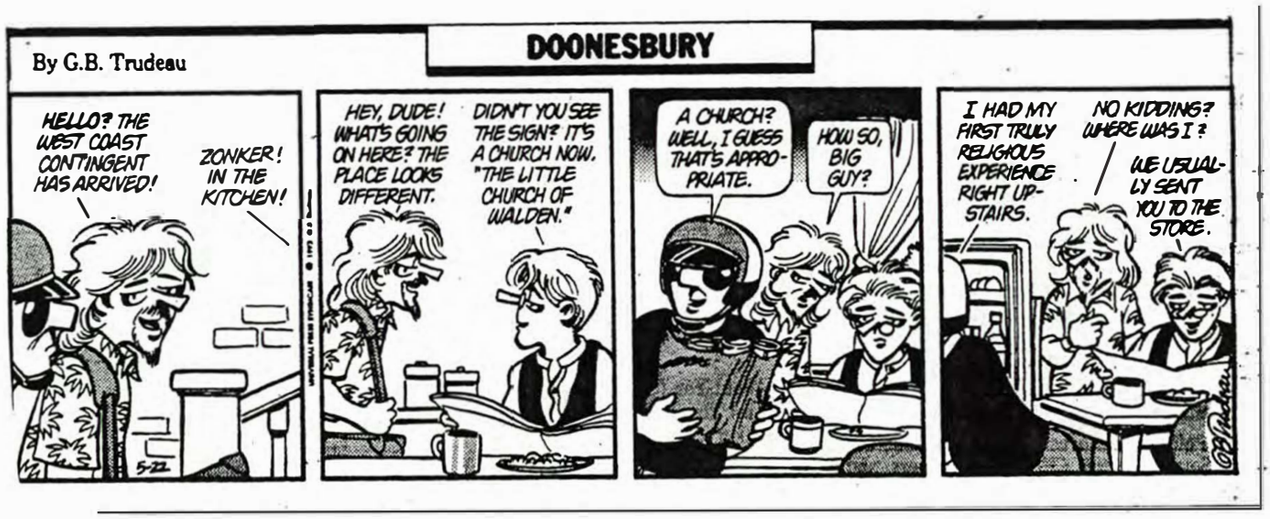
JERE REAL
Lynchburg

■

Col. Peck's revelation that his son is a homosexual and that he fears that his son's life "would be in jeopardy from his own troops" is a horrible indictment of the military and its leadership. Gen. Schwarzkopf's testimony reveals the same basic rationale. This is not about homosexuals. It's about the inability of heterosexuals to be comfortable. It's about military leadership that has all but encouraged violence toward homosexuals. I have yet to hear of one military leader speaking out forcefully against troop violence directed at homosexuals. On the contrary, they use it as a "reason" for not allowing gays in the military.

I was jolted by Col. Peck's testimony. I was jolted the fact that Col. Peck does not see the irony in his stance against lifting the ban.

DONALD L. GUISGOND
Alexandria



May 27, 1993

MEMORANDUM

To: Files
Fr: Sara ROSENBAUM
Re; Treatment of abortion

From my experience with abortion as a health law issue, I can provide two basic legislative options.

1. **Remain silent**

Under this option, abortion would be treated like any other medical item or procedure under the new benefit plan. That is, our package would cover all medically appropriate abortions.[1]

The term "medically appropriate", as we define it, is probably broader than the term "medically necessary".[2] That is, a medical appropriateness judgement might take in a broader view of a patient's overall health and psychosocial needs than a more narrow medical necessity standard.

Under an "appropriateness" standard, women who desire abortions for physical, psychological, or other reasons considered appropriate in the judgement of their provider,[3] would be covered.

---

[1] Provisions such as the Hyde amendment are needed when lawmakers want to single abortions out for specific, differential treatment.

[2] I say "probably", because of my experience with medicaid abortion litigation in the 1970s. The first Hyde amendment was enacted because of early federal court rulings that medicaid covered elective abortions. These rulings probably were incorrect, given Medicaid's medical necessity standard. Regardless, the original Hyde amendment was enacted to limit abortions only to this that were medically necessary. However, the original language of the first "medical necessity" standard was so broad that most abortions could be justified as medically necessary. hence, the increasingly restrictive language throughout the 1970s, followed by other very restrictive language to other federal programs.

[3] If we include a conscience clause, my suggestion is that we draft it to provide that any individual provider can elect not to perform the service but to also make clear that the AHP either has to find the woman another participating provider who does offer the service or else pay for the procedure on an "out-of-plan" basis. In other words, we do not want AHP corporate entities to be let off the hook simply because they enroll individual providers who refuse to honor a provision in their patients' contracts.

Absolutely elective abortions would not be covered.[4]

2. **Override the medical appropriateness standard for abortions**

If we want to fund purely elective abortions, we will have to draft an abortion-specific exception to the otherwise applicable "medical appropriateness" standard that applies to all other items and services under the bill. In other word, we could say something like :

> "Except in the case of termination of pregnancy, which shall be at the election of the patient, no item or service shall be covered unless medically appropriate".

This language would achieve elective coverage, but would place abortion in a category not commonly found in health insurance.

It is common for private health insurance plans to contain medical appropriateness standards. To the extent that abortions are paid for, this probably is because a physician notes in the woman's record that there is some type of medical need. In other cases, abortions get paid for "under the table" as dilation and curettage because of suspected problems. In other words, someone basically misrepresents the woman's condition in order to cover her procedure.

---

[4] After my experience with abortion litigation, I am still not sure from a legal viewpoint of how many absolutely elective abortions do in fact occur. I think that most women who have "elective" abortions would say they did so because they just could not handle having a child. To perform an abortion under these circumstances would be consistent with the "medical appropriateness" standard, since it would be grounded in preserving the patient's overall psychological health.

NATIONAL WOMEN'S LAW CENTER

REPRODUCTIVE HEALTH CARE AND NATIONAL HEALTH CARE REFORM

A Report by the

NATIONAL WOMEN'S LAW CENTER

Sarah Craven
Marcia D. Greenberger
Ann Kolker

May, 1993

1616 P Street, NW • Suite 100 • Washington, DC 20036 • (202) 328-5160 • FAX (202) 328-5137

The National Women's Law Center is a non-profit organization that has been working since 1972 to advance and protect women's legal rights. The Center focuses on major policy areas of importance to women and their families including employment, education, reproductive rights and health, family support and income security -- with special attention given to the needs of low-income women. This report was made possible in part by funds granted through a fellowship program sponsored by the Charles H. Revson Foundation. Statements made and views expressed, however, are solely the responsibility of the authors.

REPRODUCTIVE HEALTH CARE AND NATIONAL HEALTH CARE REFORM

EXECUTIVE SUMMARY

Reproductive health is a critical component of the health care women need throughout their lifetime. Because reproductive health care is so central to women, it is often the first type of care a woman seeks, and for many the only form of primary care they receive. Although the need is great, women encounter numerous problems in obtaining key services -- from a shortage of obstetricians and gynecologists to the failure of many insurance programs to reimburse for preventive screening. As a result, women's health, and the health of their children and partners suffer.

In spite of the inadequacies of the current system, some public and private programs provide solid coverage for women's reproductive health needs, demonstrating that it is feasible, practical and cost effective to provide critical reproductive health care services.

Abortion services are, for example, generally covered under private health insurance; an expansive array of maternal and infant health and family planning services for low-income women are supported by government programs; and support for both infertility services and treatment for sexually transmitted diseases has come from both the public and private sector. Taken together, these programs and policies provide useful models for a national health insurance scheme.

I. The Reproductive Health Care Needs of Women

Women's reproductive health care needs, which cover pregnancy, delivery and post-natal care, contraception, abortion, infertility services and treatment for reproductive tract diseases are inextricably linked. Good reproductive health care not only enhances women's health, it confers health benefits to a woman's children and partners.

Family Planning and Contraceptive Care

- For 90% of her reproductive life, the average woman either wants to postpone giving birth or avoid having more births. For only 10% of her reproductive life is a woman actually pregnant or attempting to become pregnant.

- Family planning is cost effective - for every dollar invested in public family planning services, $4.40 is saved. Experts estimate that if all pregnancies were planned, infant mortality rates could be reduced by approximately 10% and low birth weight by 12%.

Pre-natal and Maternity Care

- Approximately 3.7 million women, about 7% of all American women of childbearing age, have a baby each year. Eight out of 10 women will have at least one child by the end of their reproductive years.

- Every dollar spent on prenatal care saves $3.38 in the cost of caring for low birth weight babies. Averting one low birth weight baby can save $14,000-$30,000 in first year hospital and long-term health care costs.

Abortion

- The risk of serious complications from a legal abortion is low, and most women who have an abortion experience few if any problems getting pregnant or having healthy children in the future.

- The average cost of an abortion is about $250. Legal abortion has been associated with important declines in U.S. maternal mortality rates.

Reproductive Tract and Sexually Transmitted Diseases

- Each year more than 12 million women and men contract a sexually transmitted disease ("STD"), but the consequences are often more severe and long lasting for women than for men.

- Every year prevention and early treatment of sexually transmitted diseases saves millions of dollars in direct health care costs and millions more in the indirect costs of lost wages and decreased productivity of affected individuals. Gonorrhea and chlamydia screening and education saved as much as $193.1 million in direct health care costs and as much as $153 million in indirect costs.

Infertility

- One in every six couples is infertile or fails to conceive within a year of deciding to have a child. Infertility is a treatable reproductive disease with 50% of infertile people treated, both women and men, able to conceive.

- Among couples seeking treatment for infertility, 85 to 90% can be treated through conventional medical/surgical procedures, rather than through more expensive procedures such as in vitro fertilization.

II. Problems in Obtaining Reproductive Health Care

Because women are particularly disadvantaged under our current health care system, they are often denied access to reproductive health care. In addition, provider shortages and limitations on critical services such as family planning and abortion deny many women coverage of these services even if they have certain forms of insurance coverage.

- Women and their children are disproportionately represented among the uninsured, creating devastating consequences for women's overall health.

- The problems in obtaining adequate reproductive health care services are particularly acute, because there is a shortage of obstetrician-gynecologists and a dramatic drop in the number of doctors trained and willing to perform abortions. As of 1990, 12.2% of ob-gyns nationally had given up obstetrics and 24.2% had decreased the level of high-risk obstetric care that they provided.

- Even when they have access to providers and some health insurance coverage, women can not count on receiving the full spectrum of reproductive health services. Many programs fail to cover Pap smears, but pay for expensive procedures once cervical cancer is diagnosed.

- Barriers to reproductive health care are particularly onerous for low income women. Obstetricians, for example, are one of the health providers least likely to accept Medicaid patients; the prohibition on medicaid-funded abortion has hurt the health and economic status of poor women, considering the cost of an abortion can be more than half the average monthly income of a family on AFDC.

III. Current Models of Public and Private Coverage.

Current public and private insurance programs provide some instructive models for a more comprehensive reproductive health care approach. These programs demonstrate that it is practical, feasible and cost-effective to cover the range of reproductive health care services in a national health care reform plan.

Family Planning and Contraceptive Care Coverage

- Medicaid, the single largest source of public funding for contraceptive services, provides a favorable 90% federal-state funding match for family planning services, including all approved contraceptives.

- Some private insurance covers the full range of family planning services. For example, plans offered by M.D. IPA and Kaiser Permanente provide explicit coverage of family planning services; other plans, such as those offered by Kaiser Permanente, Sanus and Group Care, provide explicit coverage of oral contraceptive drugs and devices.

Maternity and Pre-Natal Care Coverage

- The federal government has given special priority to the needs of poor, pregnant women. Medicaid coverage has expanded to include enhanced health services for pregnant women such as risk assessment, case management, perinatal education, nutrition counseling and home visiting.

- Employer-provided private insurance policies generally cover maternity care.

Abortion Coverage

- Private insurance plans have substantial experience in coverage of abortion. An informal survey conducted by the National Women's Law Center showed that major insurance carriers such as Blue Cross Blue Shields from selected states across the country, and other major carriers including Aetna, The Principal Financial Group and Employer's Health, commonly cover abortion services.

- A similar finding was recently disclosed in another informal survey conducted by The Los Angeles Times. Spokespersons for Kaiser Permanente and Pacificare confirm that it is their general practice to cover abortion as well.

- Abortion services are covered in the Hawaii state health plan, which has been widely identified as a useful model for national health care reform.

Reproductive Tract and Sexually Transmitted Diseases Coverage

- Screening and treatment of sexually-transmitted and reproductive-tract diseases are generally covered services under most public health plans, including Medicaid.

- Private insurance often covers the diagnosis and treatment of STDs and their complications.

Infertility Coverage

- Public funding for infertility services is provided under the Title X program. Services must include initial interview, education, examination, appropriate laboratory testing, counselling and referral.

- Most progress in covering infertility has come at the state level. Ten states, Arkansas, California, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, New York, Rhode Island and Texas require insurance companies to provide coverage for infertility services.

- Private insurance coverage of several major companies offers a wide variety of services for infertility, from testing to treatments.

IV. Conclusion

Health care reform offers the promise of providing all Americans with universal, comprehensive and affordable health care. Unless comprehensive reproductive health care services are provided to women, however, the promise will fall far short for over half the population. Models from both public programs and private insurance demonstrate practical, cost effective and feasible ways of assuring women access to the full range of reproductive health care services at this historic moment when our health care system is being revamped.

REPRODUCTIVE HEALTH CARE AND NATIONAL HEALTH CARE REFORM

I. Introduction

Our nation's health care system is woefully inadequate to meet the health care needs of its citizens. Skyrocketing costs, coupled with limited or non-existent access to requisite health care services, have precluded many citizens from receiving basic health care. Although the United States spends more per capita on health care than any other country in the world, its infant mortality rate is among the highest in the industrial world, and 100,000 individuals a month continue to move into the ranks of the uninsured. Our country is the only advanced nation in the world that does not provide basic health care to all its citizens.

The Clinton Administration and Congress have made national health care reform a top priority. With policy makers considering fundamental change in the health care system, the health care needs of women have become an important part of the debate. Principles of universal access, comprehensive coverage and cost-effective and affordable care address many structural issues that have particular importance for women because of the limited coverage and economic means they now have. In addition, because reproductive health care services epitomize key differences between the health needs of men and women, the entire spectrum of reproductive health care has particular importance for women. In the past, reproductive health services have been given little attention, resulting in devastating consequences for women as well as an adverse impact on men whose reproductive health needs are inextricably linked to those of women.

This document highlights the specific reproductive health care needs of women; discusses the range of services that a national health care reform package could provide; reviews the relationship of these services to women's health care and then offers models from public and private insurers which provide these services.

II. The Reproductive Health Care Needs of Women

Reproductive health care is a critical component of the health care women need throughout their lifetime. Moreover, such care confers health benefits to a woman's children and sexual partners. Because reproductive health care is so crucial, it is often the first type of care a woman seeks, and for many the only form of primary care they receive.

Women's reproductive health care includes pregnancy, delivery and post-natal care; contraception; abortion; infertility services; and treatment for reproductive tract diseases, which are the leading contributors to conditions such as infertility and cancer.

All aspects of reproductive health are inextricably linked. For example, the safe and effective use of contraceptives can greatly enhance women's health by enabling them to space or limit their pregnancies. Likewise, the health of a pregnant woman, her baby, and her sexual partners can be severely compromised by reproductive tract infections and sexually-transmitted diseases that are left unchecked and untreated. Access to early abortion is far safer than childbirth, and for women carrying pregnancies to term, prenatal care not only leads to healthier babies, but also healthier mothers.

As the following information reveals, early prevention, diagnostic screening, education, prescription drugs, devices and treatment all combine to meet the panoply of women's reproductive health care needs.

Family Planning and Contraceptive Care

Family planning services, including access to contraceptive care, are essential to women's health.[1] For 90% of her reproductive life, the average woman either wants to postpone giving birth or avoid having more births. For only 10% of her reproductive life is a woman actually pregnant or attempting to become pregnant.[2] Of the 58 million U.S. women of reproductive age, 67% are at risk of an unintended pregnancy.[3] Accordingly, for the decades that span from adolescence to menopause, women require access to family planning services, including safe and effective contraceptive methods.

Effective family planning services and contraceptive care improve the health of women by assisting them to avert unintentional pregnancies, space their children and reduce the need for abortions. Further, some contraceptive methods can assist women and their partners in preventing transmission of sexually transmitted diseases. Moreover, family planning is cost effective; for every dollar invested in public family planning services, $4.40 is saved.[4]

Healthy children also depend on women receiving effective family planning services. Women who become pregnant unintentionally are more likely to have poor birth outcomes and are less likely to seek early prenatal care.[5] The National Commission to Prevent Infant Mortality estimates that if all pregnancies were planned, infant mortality rates could be reduced by approximately 10% and low birth weight by 12%.[6] Furthermore, a recent study by the Alan Guttmacher Institute concluded that avoiding birth intervals of less than two years could be expected to reduce by 5-10% the rate of low birth weight babies and the neonatal death rate.[7] Moreover, unwanted and unplanned children are at an increased risk for abuse and neglect.[8]

In many cases, women need an on-going relationship with their family planning providers in order to receive the necessary medical care to avoid an unintended pregnancy. Almost 13 million women of reproductive age obtain their family planning care in a doctor's office or HMO and 7.1 million women receive care in a clinic.[9] Of the women at risk of unintended pregnancy who use a contraceptive method, 13.4 million women use a reversible contraceptive method such as the pill, the diaphragm or the IUD, that at least initially requires medical supervision, including instruction on how to effectively use the drugs and devises.[10] It is estimated that 25% of women do not properly utilize their contraceptive methods.[11] Without access to medical practitioners and clinics, women's contraceptive options remain limited and less effective.

Pre-natal and Maternity Care

Approximately 3.7 million women, about 7% of all American women of childbearing age, have a baby each year.[12] Eight out of ten women will have at least one child, and many will have had two or three children by the end of their reproductive years.[13] For many women, pregnancy and childbirth do not cause adverse health consequences of any magnitude. However, three in ten mothers are reported by their physicians to have had major health complications which can result in threats to the lives of both mother and child, adding considerably to the costs of medical care, and six of every ten mothers have some medical complications during their pregnancy.[14]

Prenatal care that begins early and continues throughout pregnancy can prevent low birthweight as well as infant mortality. Infants born to mothers who receive inadequate care are significantly more likely to die in infancy or be left with lifelong disabilities. According to a study by the Alan Guttmacher Institute, the infant mortality rate is 9.7 per 1,000 live births among newborns whose mother began prenatal care in the first trimester. It rises to 12.5 per 1,000 where care was initiated later in pregnancy. And it jumps to 48.7 per 1,000 cases where the mother obtained no prenatal care at all.[15] The high correlation between the absence of prenatal care and poor birth outcomes alone underscores the importance of this health service.

Many women, however, do not obtain prenatal care early enough, do not make enough prenatal visits, or do not get care throughout pregnancy. In 1988, for example, more than one million of the 3.9 million infants born that year had mothers who did not receive any prenatal care during the first three months of pregnancy.[16] Nearly 250,000 babies were born to women who received no care until the last three months of pregnancy or who received no care at all.[17] As a result, the risks of serious health consequences for the infant increase substantially.

In addition to affecting the health of the child, late or no prenatal care compromises the health of the mother. Late or no prenatal care leaves women without access to basic health services which permit detection and treatment of potential health problems or the opportunity to address such problems as use of drugs, alcohol, or tobacco during pregnancy. Women

without prenatal care may go without necessary nutritional supplementation or access to highly specialized inpatient services. Without this access and care, pregnancy and childbirth become a risky experience for both mother and child.

Further, effective maternal health services are proven cost effective measures. Every dollar spent on prenatal care saves $3.38 in the cost of caring for low birth weight babies.[18] Averting one low birth weight baby can save $14,000-$30,000 in first-year hospital and long-term health care costs.[19] The Special Supplemental Food program for Women, Infants and Children ("WIC") is also very cost effective. The health care and food supplements it provides to pregnant women, nursing mothers, infants and young children have produced savings of two to three dollars for every one dollar spent on WIC during pregnancy.[20]

Abortion

Abortion is a safe and effective procedure to terminate an unwanted pregnancy. The risk of serious complications from a legal abortion is low, and most women who have an abortion experience few if any problems getting pregnant or having healthy children in the future.[21] Increased physician education and skills, improvements in medical technology, and the trend towards earlier termination of pregnancy have only increased the safety of legal abortion. According to the American Medical Association ("AMA"), the risk of death due to a legal abortion is substantially lower than that associated with a pregnancy which is carried to term.[22] In 1985, for example, approximately nine women out of every 100,000 died during childbirth, a mortality rate more than 10 times as high as the abortion death rate.[23]

As medical authorities point out, abortion "is safest for a woman when performed early in pregnancy and by a well-trained, experienced physician working in a setting equipped to handle complications that might arise."[24] However, complications from legal abortion, physical or emotional, are now very rare.[25] The straightforward nature of the procedure is reflected in the fact that the average cost of an abortion is about $250.[26] Significantly, legal abortion has been associated with important declines in U.S. maternal mortality rates.[27]

Reproductive Tract and Sexually Transmitted Diseases

Sexually Transmitted Diseases

Each year more than 12 million women and men contract a sexually transmitted disease ("STD").[28] Women account for about half of all sexually transmitted infections that occur each year, but they suffer more frequent and severe long-term consequences than men.[29] For example, STDs can lead to pelvic inflammatory disease, infertility, cervical cancer, ectopic pregnancy, infant pneumonia and death, mental retardation, immune deficiencies and the death of infected individuals.[30] Untreated syphilis can enter the bloodstream and cause lung and heart

damage and meningitis. The incidence of syphilis in the United States rose to its highest level in 40 years in 1989.[31]

The health risks of these diseases multiply when, undetected and untreated, STDs are passed on to a sexual partner or by a pregnant woman to her unborn child. Sizable portions of both women and men of all socioeconomic groups are exposed to the health risks of STDs through direct or indirect contact with multiple sexual partners. According to the 1988 National Survey of Family Growth and the 1988 and 1989 General Social Surveys, 67% of all women aged 15-44 who have ever had intercourse have had more than one partner, 41% have had four or more, and 23% have had six or more.[32]

Every year prevention and early treatment of sexually transmitted diseases saves millions of dollars in direct health care costs and millions more in the indirect costs of lost wages and decreased productivity of affected individuals.[33] For example, gonorrhea and chlamydia screening and education saved as much as $193.1 million in direct health care costs and as much as $153 million in indirect costs.[34]

The advent of AIDS has markedly increased the awareness of the substantial threat of STDs. Women, particularly women of color, are the fastest growing HIV-positive group in the United States. Of the 1.5 million people who had been infected with the HIV virus as of September 1991, an estimated 300,000 to 400,000 of these were women and 19,796 had been diagnosed with AIDS.[35] Women who are diagnosed with AIDS tend to die twice as quickly as men with the same diagnosis, and 63% will die of HIV complications without ever having been officially diagnosed as having AIDS.[36]

Condom use is the best known way for sexually active women to avoid sexual transmission of HIV, the virus which causes AIDS. Experts stress that STD prevention and education efforts must include a discussion of AIDS as a disease which is transmitted largely through sexual contact. Since there is no known cure for AIDS, these education efforts are of major importance, particularly for those individuals who may engage in high-risk behaviors or are sexually active with partners who engage in such behavior.

Reproductive Tract Diseases

Reproductive tract diseases such as cervical cancer also threaten women's lives, although screening, early diagnosis and treatment can prevent the cancer from becoming invasive. Indeed, experts suggest that if women received regular Pap smears and diagnostic colposcopies when indicated, the incidence of death from cervical cancer would be significantly reduced if not eradicated. In the United States, cervical cancer causes over 4,500 unnecessary deaths among women each year, largely due to economic barriers in receiving a pap smear.[37] The American Cancer Society recommends annual pap smears for all women who are or have been sexually active or have reached age 18.[38] Early screening is equally important for breast

cancer, which is the most common form of cancer in American women, affecting one in nine women in the course of her lifetime. Experts estimate that regular mammography screening which can detect breast cancer in its earliest, most treatable stage, can reduce mortality rates by 30%.[39]

Early detection of these diseases prevents other complications as well. For example, hysterectomy, the second most common major operation performed in the United States, is often the first course of treatment for a wide range of disorders, despite the fact that less radical and less expensive treatments are very often available and effective. Moreover, hysterectomy sometimes becomes necessary because women fail to receive regular gynecological care which would detect uterine problems such as cervical cancer in time to prevent the need for such radical surgery.[40] The fact that women with incomes of less than $10,000 a year, those least able to afford preventive testing, are the most likely to have the procedure illustrates the serious consequences which result when primary care or routine screening is unaffordable or unavailable.[41]

Infertility

Over 2.3 million couples struggle with the disease of infertility.[42] One in every six couples is infertile or fails to conceive within a year of deciding to have a child.[43] Infertility is a treatable reproductive disease, with 50% of infertile people treated --- both women and men -- able to conceive.[44] Each year, close to one million couples seek medical advice or treatment for infertility.[45] The number of infertility-related visits to doctors has nearly quadrupled over the last 20 years.

This essential reproductive health care service, however, often requires several visits to the doctor as well as various tests, monitoring and treatment. A complete infertility diagnostic workup for a woman, for example, can take four or five menstrual cycles, with many of the diagnostic tests that can not be combined having to be scheduled at specific times in her cycle.[46] While the risk of infertility is one and a half times greater for African-Americans than for whites and is more common among people with less than a high school education, whites and those with higher incomes are more likely to pursue infertility treatment.[47]

Infertility is a curable disease that can be treated cost effectively. Among couples seeking treatment for infertility, 85-90% can be treated through conventional medical/surgical procedures, rather than through more expensive procedures such as in vitro fertilization.[48] Moreover, the cost of infertility diagnosis and treatment, when spread over the insured population, is relatively small. In Massachusetts, for example, policyholders paid $1.70 per family contract per month in 1990 to cover infertility.[49]

III. Problems in Obtaining Reproductive Health Care

Because women are particularly disadvantaged under our current health care system, they are often denied access to reproductive health care. For example, because of their lower earnings and concentration in service and retail jobs, which have low rates of employer-provided insurance, women and their children are disproportionately represented among the uninsured. Absence of health insurance has devastating consequences for women's overall health, denying them access to vital treatment or forcing them to miss prenatal care while pregnant. The failure of our health care delivery system to serve poor and rural areas takes a serious toll on many pregnant women and their infants. Even when available, care for preventive service is often not a covered service, putting routine check ups and screening tests out of reach for many women.

The problem in obtaining adequate reproductive health care services is particularly acute, because there is a shortage of obstetrician-gynecologists and a dramatic drop in the number of doctors trained and willing to perform abortions. As of 1990, 12.2% of ob-gyns nationally had given up obstetrics and 24.2% had decreased the level of high-risk obstetric care that they provided.[50] In some states, the problem is worse than the national figures show. According to a 1990 report of western states, 39.7% of physician providers of obstetric services indicated that they had plans to leave obstetrics within the next year.[51] Seven out of ten of New York's family physicians, almost 40% of Texas family physicians and approximately one-half of Nevada's rural family physicians, have also stopped practicing obstetrics.[52]

Moreover, fewer doctors are trained and ready to perform abortions. More than one in four obstetrics and gynecology residency programs offer no abortion training, creating a severe shortage of physicians who can perform abortions.[53] Already, half of the nation's urban counties and 93% of local counties, where one third of American women reside, do not have an abortion provider.[54] The last North Dakota doctor who performed abortions retired in 1989, and in South Dakota and Montana there is only one physician in the state willing to accept abortion patients.[55] As the American Medical Association points out, as access to safer, earlier legal abortion becomes increasingly restricted, there is likely to be a small but measurable increase in mortality and morbidity among women in the United States.[56]

Even when they have access to providers and some health insurance coverage, women can not count on receiving the full spectrum of reproductive health services. In some instances both providers themselves and third party payers, private and public, have declined to provide or reimburse for family planning, contraception, abortion, and infertility services. For example, many publicly funded programs (and, often, private insurance plans) fail to cover pap smears, yet pay for expensive procedures once cervical cancer is diagnosed. In other instances, vital family planning and abortion services have been restricted by policy makers bowing to political pressure.

Barriers to reproductive health care are particularly onerous for low-income women because of limitations and inadequacies in the Medicaid program, the largest source of publicly funded health insurance. Obstetricians, for example, are one of the health providers least likely to accept Medicaid patients.[57] In recent years there has been a drop in Medicaid participation by ob-gyns and pediatricians. A 1987 survey found that only 63% of ob-gyns were accepting Medicaid, while the percentage of pediatricians accepting Medicaid dropped from 85% to 77% between 1978 and 1989.[58] As a result, adequacy of prenatal care varies according to accessibility - 81% of privately insured, but only 36% of Medicaid beneficiaries, and 32% of uninsured women receive adequate prenatal care. Finally, Medicaid does not cover single people in poverty or women who are poor and no longer have dependent children.

Additional obstacles have been placed on low-income women through limitations on abortion coverage. Prior to 1977, abortion services were available to Medicaid recipients in most states. Since 1977, however, federal Medicaid funding essentially has been non-existent despite the fact that the cost of an abortion can be more than half the average monthly income of a family on AFDC. Federal Medicaid funds may now be used for an abortion only if the life of the woman is endangered. Only 13 states continue to use their own revenues to provide all legally available abortion services for low income women. Clearly this decision is not based on cost factors. A state by state analysis reveals that for every tax dollar spent to pay for abortions for poor women, an average of four dollars is saved in public medical and welfare expenditures.[59]

Middle income women may have difficulty in obtaining critical reproductive health care services. Although the Pregnancy Discrimination Act generally mandates private employer coverage of pregnancy, for women insured through individual or non-employer-based plans, private insurance maternity coverage is sometimes spotty or limited, with riders or other special requirements not in place for other conditions. Women with private insurance may also be denied coverage due to a waiting period for preexisting conditions that include pregnancy. In fact, about nine percent of women of reproductive age, some five million women, have private insurance policies that do not cover maternity care at all.[60] These women are forced to rely on their own private funds or, if they qualify, to apply for Medicaid.

A shortage of providers and incomplete public and private insurance coverage, as well as a contentious political climate, deny many women coverage to basic reproductive health care. The rapid rise of sexually transmitted diseases, the limited scope of contraceptive options, and the lack of access to safe abortion services further aggravate the problem. Despite the central and crucial nature of reproductive health care, under our current health care system, American women have no guarantee of receiving the reproductive health care they critically need.

IV. Current Models of Public and Private Coverage

Our current patchwork of public and private insurance provides some instructive models for a more comprehensive health care approach. Despite the serious gaps in those who receive coverage and the coverage they receive, there are coverage models which have filled women's reproductive health care needs. They are described below.[61]

Family Planning and Contraceptive Care Coverage

The federal government has long recognized the importance of contraceptive services by providing funding for family planning services in several programs. Medicaid, the single largest source of public funding for contraceptive services, provides a favorable 90% federal-state funding match for family planning services, including all approved contraceptives. In addition, the federal government dedicates one federal program, Title X of the Public Health Service Act, solely to these services. Each year over 3.7 million low-income women receive family planning services through Title X clinics. These clinics are frequently a woman's first and only entry point into the health care system, and as a result play a role far broader than providing contraceptive care alone.

This federal commitment is mirrored by the growing recognition among private insurers that family planning is an essential and cost-effective service. Emerging evidence suggests that there is an increase in private insurance coverage for the full range of family planning services, from pre-conception counseling to surgical sterilization. Private insurance plans offered by M.D. IPA and Kaiser Permanente of the Mid-Atlantic States offer examples of explicit coverage of family planning services, including counseling, genetic counseling, examinations, removal of devices and prescriptions for birth control methods. In fact, it is not unusual for private insurance to provide coverage for contraceptive drugs and devices. Many plans, such as those offered by Sanus and Group Care, provide explicit coverage of oral contraceptive drugs including the implanted time release contraceptive, Norplant, in addition to contraceptive devices such as diaphragms and IUDs. In other cases, health plans include family planning supplies in their general coverage of prescription drugs. Aetna HMO and Northwestern National Life provide examples of this approach. Moreover, some plans such as Kaiser Permanente and Blue Cross/Blue Shield, provide coverage for sterilization. This trend in private insurance demonstrates that private reimbursement for family planning services is becoming more common.

Maternity and Pre-Natal Care Coverage

In recent years, while far from meeting the need, Congress has given special attention to the need of poor, pregnant women. It has required expansion of Medicaid coverage for many poor women who would not normally be covered under their states' Medicaid program, and enhanced the health services for pregnant women to include risk assessment, case management,

perinatal education, social services consultation, nutrition counseling and home visiting. When fully implemented, this expanded Medicaid coverage will serve more than 500,000 additional pregnant women and some four million children annually, making the program one of the largest sources of health care financing and services for maternity and child health coverage. The Maternal and Child Health Block Grant provides further federal funding to states for necessary pre and post-natal maternal care and maternal and child nutrition services. Finally, the Supplemental Food Program for Women, Infants, and Children (WIC) provides necessary nutrition counseling and food supplements in order to assist low-income pregnant and nursing women as well as infants and young children.

Most employer-provided private insurance policies cover maternity care since the Pregnancy Discrimination Act, an amendment to Title VII, requires employers with fifteen or more employees to cover pregnancy care in the same manner as they cover other services.

Abortion Coverage

Private insurance plans have substantial experience in coverage of abortion. An informal survey by the National Women's Law Center confirmed that major insurance carriers including a number of Blue Cross-Blue Shields from across the country as well as Aetna, The Principal Financial Group, and Employer's Health all report that they commonly provide coverage for abortion services.[62] Indeed, Michael Chee, a spokesman for Blue Cross of California stated, "This is not a new phenomenon. Private insurance has paid for abortion for quite a while."[63]

A similar finding was recently reached in an informal survey conducted by the L.A. Times. Spokepersons for Blue Cross-Blue Shield of California, Pacificare Health Systems, Inc., and Kaiser Permanente indicated that it is the practice of their companies to cover abortion services.[64] In conjunction with this survey, the Health Insurance Association of America and Foster Higgins & Co, one of the nation's largest health care consulting firms, maintained that abortion is "safe, proven, cost effective and worthy of insurance coverage."[65]

Insurance coverage for abortion services can also be found in some state health care plans. Hawaii, for example, has enacted a triad of public and private insurance programs to ensure universal access to health care for all its residents. The standard benefit package for each of Hawaii's three insurance programs provides coverage for surgical services for the termination of pregnancy.[66]

Reproductive Tract and Sexually Transmitted Diseases Coverage

Screening and treatment of sexually-transmitted and reproductive-tract diseases are general covered services under most public health plans. Physician, clinic and laboratory services for the diagnosis and treatment of STDs are explicitly covered under Medicaid. In addition to contraceptive services, Title X clinics provide a wide array of essential reproductive health care

including screening for breast and cervical cancer, and STD and HIV services. Additionally, Section 318 of the Public Health Service Act provides authority for the Center for Disease Control to award grants to state and local health departments to provide STD prevention and control services. In FY 1986, for example, CDC project grants resulted in 7.4 million high-risk women being screened for gonorrhea as well as 147,000 receiving treatment.[67]

Private insurance often covers the diagnosis and treatment of STDs and their complications, subject to the usual deductibles, co-payments and other conditions imposed by private insurers. Testing for the HIV virus and AIDS normally would be covered under private health insurance if there is a reason to suspect illness unless excluded under restrictions preventing coverage of prior conditions. A study by the Office of Technology Assessment found that screening of individual applicants for insurance for HIV infection was quite common.[68]

Infertility Coverage

At the federal level, Title X provides public funding for infertility services by authorizing grants "to assist in the establishment and operation of family planning methods, infertility services, and services to adolescents." According to Title X program guidelines, grantees, at a minimum, must provide an initial infertility interview, education, examination, appropriate laboratory testing, counselling and referral. Although the federal Medicaid statute does not preclude coverage for infertility treatment, no state has paid for these procedures as of 1987. Some states have reported that they would pay for infertility procedures if a reimbursement claim was submitted.[69]

Most progress in covering infertility has come at the state level. Ten states, Arkansas, California, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, New York, Rhode Island and Texas require insurance companies to provide coverage for infertility services. These laws vary widely, from requiring insurers to provide 100% coverage of the diagnosis and treatment of fertility to requiring insurers only to offer coverage which the employer has the option to purchase.[70] Cost data available from states with infertility insurance mandates support the fact that the medical costs borne by an individual infertile couple are minute when spread across a large pool of insurance policyholders.[71]

Private insurance coverage offers a wide variety of covered services for infertility. Northwestern National Life's plan, for example, covers the full range of infertility services including diagnostic and therapeutic treatments. In a similar manner, the Guardian Life Insurance Co. of America's plan explicitly covers infertility services if a couple has been unable to attain a successful pregnancy through other means. The Health Insurance Association of America (HIAA) estimates that 40% of people covered under private insurance have coverage for some services related to infertility.[72]

V. Conclusion

Women have comprehensive reproductive health care needs which require comprehensive health care services. Pregnancy, family planning, contraception, abortion, sexually-transmitted and reproductive tract diseases, and infertility are not isolated and unrelated events, but inter-linked health care needs which require complementary and coordinated services. Coordinated and comprehensive reproductive health care services not only benefit women, but also confer benefits on men, children and families. Moreover, comprehensive reproductive health care is cost effective. The lessons of both public and private insurance models show conclusively that coverage for a broad spectrum of female reproductive health services is both feasible and affordable.

Health care reform offers our nation a unique opportunity to restructure our health care system in order to provide all Americans with universal, comprehensive and affordable health care. As the evidence amply demonstrates, reproductive health care is part of that equation. The health of our nation depends on it.

SOURCES

1. Family planning services include counseling and medical services to help individuals or couples plan the timing and spacing of their children. Contraception, an integral aspect of family planning, assists individuals in preventing unwanted pregnancies.

2. The Alan Guttmacher Institute, Blessed Events and the Bottom Line: Financing Maternity Care in the United States, New York, 1987.

3. The Alan Guttmacher Institute, Facts in Brief: Contraceptive Use, New York, 1988.

4. The Alan Guttmacher Institute, "The Cost Benefit of Publicly Funded Family Planning Services," Issues in Brief, Washington, D.C. March 1990.

5. Jamieson, Denise J. and Buescher, Paul A., The Effect of Family Planning Participation on Prenatal Care Use and Low Birth Weight, Family Planning Perspectives, Vol. 25, 214, 1992.

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

7. Jamieson, Denise J. and Buescher, Paul A., The Effect of Family Planning Participation on Prenatal Care Use and Low Birth Weight, Family Planning Perspectives, Vol. 25, 214, 1992.

8. S.J. Zuravin, Unplanned Childbearing and Family Size: Their Relationship to Child Neglect and Abuse, Family Planning Perspectives, Vol. 23, 155, 1992.

9. The Alan Guttmacher Institute, Facts in Brief: Contraceptive Services, New York, 1990.

10. Ibid.

11. National Council on Patient Information and Education, Women and Medicines, Washington, D.C. 1991.

12. The Alan Guttmacher Institute, Blessed Events and the Bottom Line: Financing Maternity Care in the United States, New York, 1987.

13. Ibid.

14. Ibid.

15. Ibid.

16. Children's Defense Fund, The Health of America's Children, Washington, D.C., 1991.

17. Ibid.

18. Institute of Medicine, Preventing Low Birthweight, National Academy Press, Washington, D.C. 1985.

19. The Alan Guttmacher Institute, Blessed Events and the Bottom Line: Financing Maternity Care in the United States, New York 1987.

20. Food and Nutrition Service, "The Savings in Medicaid Costs for Newborns and Their Mothers from Prenatal Participation in the WIC Program". U.S. Department of Agriculture, October 1990.

21. The Alan Guttmacher Institute, Abortion and Women's Health, New York, 1990.

22. The Council on Scientific Affairs, Induced Termination of Pregnancy Before and After Roe v. Wade: Trends in the Mortality and Morbidity of Women, American Medical Association, May, 1992.

23. Ibid.

24. Ibid.

25. The Alan Guttmacher Institute, Abortion and Women's Health, 1990.

26. The Alan Guttmacher Institute, Facts in Brief, Abortion, New York, NY, 1993.

27. Ibid.

28. Division of STD/HIV Prevention, Division of STD/HIV Prevention 1992 Annual Report, Center for Disease Control, Atlanta, 1993 (forthcoming).

29. Donovan, Patricia, Testing Positive: Sexually Transmitted Disease and the Public Health Response, The Alan Guttmacher Institute, New York, 1993.

30. Althaus, F. An Ounce of Prevention...STDs and Women's Health, Family Planning Perspectives, Vol. 23, 173, 1991.

31. Jacobson, Jodi L., Women's Reproductive Health: The Silent Emergency, Worldwatch Institute, Washington, D.C., June 1991.

32. Kost, Kathryn and Forrest, Jacqueline D., American Women's Sexual Behavior and Exposure to Risk of Sexually Transmitted Diseases, Family Planning Perspectives, Vol. 25, 242, 1992.

33. Schwartz, Allyson Y, State Senator, Pennsylvania Women's Health Security Act Briefing Book, 1992.

34. Ibid.

35. Boston Women's Health Collective, The New Our Bodies, Ourselves, Simon and Schuster, Inc., New York, 1992.

36. Ibid.

37. Squires, Sally, The Importance of Pap Tests, Washington Post, HEALTH, July 24, 1990.

38. Ibid.

39. Office of Senator Brock Adams, Mammography Facts, Washington, D.C., on file with the National Women's Law Center.

40. Squires, Sally, The Importance of Pap Tests, Washington Post, HEALTH, July 24, 1990.

41. Colburn, Don, Hysterectomies Likelier for Poor Women Washington Post, Feb 2, 1993.

42. The American Fertility Society has defined infertility as the inability to conceive after one year of intercourse without contraception. This definition may also include the inability of a woman to carry a pregnancy to a live birth. Both the American Fertility Society and the American College of Obstetricians and Gynecologists (ACOG) recognize infertility as a disease.

43. American Fertility Society, Infertility and National Health Care Reform Fact Sheet, Washington, D.C., October 1992.

44. The Boston Women's Health Collective, The New Our Bodies, Ourselves, Simon and Schuster, Inc., New York, 1992.

45. Ibid.

46. Ibid.

47. American Fertility Society, Infertility and National Health Care Reform, October, 1993.

48. Ibid.

49. Ibid.

50. The American College of Obstetricians and Gynecologists, Medical Liability - Its Impact on Women's Health Care Fact Sheet, Washington, D.C., October, 1992.

51. Ibid.

52. Ibid.

53. Schreiber, Lee Ann, Where Are The Doctors Who Will Do Abortions?, Glamour September, 1991.

54. The Alan Guttmacher Institute Fact Sheet: Abortion, New York, 1990.

55. Schreiber, Lee Ann, Where Are The Doctors Who Will Do Abortions?, Glamour, September, 1991.

56. Ibid.

57. Congressional Research Service, Medicaid Source Book, Washington, D.C., January, 1993.

58. Ibid.

59. The Alan Guttmacher Institute, Abortion and Women's Health, Washington, D.C., 1990.

60. The Alan Guttmacher Institute, Blessed Events and the Bottom Line: Financing Maternity Care in the United States, New York, 1987.

61. All private insurance plans referred to are on file with the National Women's Law Center.

62. National Women's Law Center Telephone Survey May 19-24, 1993. Spokespeople for Blue Cross-Blue Shield of Arkansas, California, Illinois, Ohio, and Virginia, and Aetna, The Principal Financial Group and Employer's Health all independently confirmed that they commonly provide coverage for abortion services under their respective private insurance plans.

63. Ibid.

64. Levine, Bettijane, "A Belated Debate over Abortion Funding?" L.A. Times, April 22, 1993.

65. Ibid. Most private insurance policies cover abortions in the same way that services for any other medical condition would be covered.

66. Hawaii State Health Insurance Program Act 1989.

67. The Alan Guttmacher Institute, The Need, Availability and Financing of Reproductive Health Services, New York, 1989.

68. Office of Technology Assessment, AIDS and Health Insurance, Washington, D.C., 1988.

69. American Fertility Society, Infertility and National Health Care Reform, Washington, D.C., October, 1992.

70. Ibid.

71. Ibid.

72. The Alan Guttmacher Institute, The Need, Availability and Financing of Reproductive Health Services, Washington, D.C., 1989.

MEMORANDUM

To: Ira Magaziner, Melanne Verveer, Chris Jennings

From: Shirley Sagawa

Re: Abortion issue

Date: June 22, 1993

This memo is to make you aware of a health care/abortion issue that was raised on the national service bill and how it was addressed.

The national service bill provides that every participant who does not otherwise have access to health care receive health care benefits. Eighty-five percent of the cost of the premium is paid by the federal government with the remainder paid by the local program sponsor. The minimum benefits that must be included in the plan will be set by the federal government. Participants who already have health insurance through a spouse, parent or otherwise do not receive health care benefits.

At the request of the Catholic Conference, the House Education and Labor Committee added a religious tenets exception. This exception provided that religious programs need not comply with the minimum benefits requirements if it would conflict with the religious tenets of the program sponsor. Women's groups, however, raised concerns that this exception created a situation in which the federal government paid for a substandard health care plan.

The following compromise resolved the issue, although both sides say this should not be considered a precedent for health reform: The religious tenets exception was dropped. To receive federal support for the health care benefits, a program must provide the minimum benefits. A program wanting to provide an alternative package of benefits may do so only if it is of equal value to the minimum benefits package and is paid for 100 percent by the local program. The cost of the premium paid by the local program in such a case may be counted against the required match of federal funds.

Abortion

VA Answer to Question 3 Submitted by Senator Frank H. Murkowski in Followup to the June 23, 1993, SVAC Hearing on Legislation Concerning VA Health Care Programs

Question: Chairman Rockefeller's women's health bill would create a number of new programs, including "reproductive health services." If the bill were to include abortion as one of the services defined under these so-called reproductive health services, would the Administration support or oppose the bill, and why? Should Congress fail to define the term "reproductive health," would the VA or the Administration define it to include or exclude abortion, and why?

Answer: Absent Congressional direction, we are not prepared at this time to conclude that the term "reproductive health" should or should not include abortions.

May 27, 1993

MEMORANDUM

TO: Melanne Verveer
Deputy Chief of Staff to
The First Lady

FROM: Linda Bergthold LB

RE: Attached Revised Definition of "Medically Appropriate"

Attached is a revised and annotated version of the definition of "medically appropriate". An earlier version and memo is in the Briefing Book on Reproductive Health Services we have prepared for The First Lady.

In addition to the people listed in Attachment A, we have consulted with the following people within the past week and will incorporate their suggestions:

1. Ruth Katz, Karen Nelson, Tim Westmoreland, and Mike Hash of Congressman Waxman's staff

2. Sarah Rosenbaum

3. Bill Sage, MD, JD (Leader of Cluster III – he has been helping us with the most recent revisions)

4. Harriet Rabb and Steve Neuarth both have this revised version

Our next steps are to send a final draft to all members of our Working Group for their information. The attached version will be incorporated into the drafting language of the Act, with some minor revisions.

Bill and I would be happy to talk to you and The First Lady about this definition. Please leave me a message at (202) 331–5295 or call Bill at 456–2598 if you need further information.

COVERAGE POLICY FOR TREATMENTS IN THE BENEFIT PACKAGE

Note: These provisions determine coverage of specific treatments potentially included in the enumerated categories of services within the nationally guaranteed benefit package. They are not intended to expand the scope of services beyond those enumerated categories. Inclusion of these provisions in the Act is necessary to facilitate the development of integrted delivery systems by making clear to providers and enrollees which services will be covered. It should be noted that these provisions govern coverage of health services, not their use, and do not affect the legality of delivering those services (including the ability of a given type of provider to deliver them), which is intended to remain subject to applicable state and federal law.

I. Treatments that are medically appropriate shall be covered.

A. A "**treatment**" is an intervention intended to improve significantly the physical or psychological condition of the enrollee or to prevent or mitigate a health outcome adverse to the enrollee.

Note: The term "treatment" is intended to encompass a variety of interventions, in addition to therapy for acute illness or injury, that provide physical or psychological benefit to the enrollee, including preventive care, care for disabilities and reproductive care.

1. "**Intervention**" means a diagnostic, therapeutic or other health-related procedure or service described by the following parameters: (i) the physical or psychological characteristics of the enrollee to whom the intervention is applied; (ii) the technical method of applying the intervention; (iii) the type of provider applying the intervention; and (iv) the setting in which the intervention is applied.

Note: "Intervention" is intended to include diagnosis, prevention and other health services as well as therapy. Defining interventions along certain specified dimensions is not intended to expand or restrict coverage but to allow treatments to be evaluated for medical appropriateness. For example, "a mammogram in a healthy woman under 30 with no family history" is clearer than "a mammogram"; "a decongestant for childhood otitis media" is more specific than "a decongestant"; "pre-anesthesia evaluation by a physician assistant" is more informative than "pre-anesthesia evaluation"; and "home antibiotic therapy for endocarditis" is more helpful than "antibiotic therapy for endocarditis." However, this provision should not be read as establishing, in federal law, any particular level of documentation as a prerequisite for coverage.

2. " **Adverse health outcome**" means a physical or psychological condition that constitutes a significant adverse change or a physical or psychological condition that lies outside the normal range.

Note: A "treatment" should be administered with the intent of affecting the enrollee's health to a significant degree; for example, cholesterol-lowering drugs should be given in order to reduce the risk of cardiovascular disease, not merely to alter the measured value of serum cholesterol. In addition, conditions being corrected should be disabilities, not normal variations. Reconstructive surgery for a cleft palate is a "treatment," while cosmetic facial surgery is not. Similarly, prevention of a significant change in health, such as the development of cancer, is a "treatment," while an attempt to prevent normal aging is not.

B. A treatment is "medically appropriate" if it is effective, beneficial and judicious.

1. "**Effective**" means that, in the reasonable judgment of the provider at the time the treatment is administered, sufficient evidence exists to conclude that the benefits to the enrollee of the treatment outweigh its risks.

Note: By setting a reasonableness standard, "effective" is intended to require objective, scientific evidence of net benefit to the enrollee. Because it is not possible to weigh the risks and benefits of experimental or investigational treatments, it is intended that such treatments not be considered effective. For treatments developed in the future, nationally sponsored or approved clinical research will assist providers in determining effectiveness. Additionally, in the definitions of "effective" and of "beneficial" below, it is intended that the term "risks" encompass all outcomes harmful or adverse to the enrollee, including side effects.

2. "**Beneficial**" means that, in the subjective judgment of the enrollee at the time the treatment is administered, the benefits of the treatment outweigh its risks; provided, however, that emergency treatment administered to the enrollee shall be deemed to be beneficial.

Note: "Beneficial" is intended to emphasize the importance of the enrollee in the decision to administer a treatment. Because these provisions govern coverage, not legitimacy, "beneficial" is not intended to correspond precisely to prevailing medical ethics or the law of informed consent (to which plans would be subject under enterprise liability). It is intended that emergency treatment be deemed beneficial and that treatments administered to persons subject to legal guardianship under the applicable law of informed consent be judged beneficial by the guardian. However, treatments not judged "beneficial" should not be administered by providers with the expectation of payment.

3. A treatment is "**judicious**" unless, in the reasonable judgment of the plan before the treatment is administered, another medically appropriate treatment is available that would be (i) substantially as effective for the enrollee and (ii) significantly less costly to the plan.

Note: "Judicious" is intended to allow and encourage plans to develop practice guidelines that will permit the delivery of high-quality care within a budget. In order to avoid covering an injudicious treatment, a plan must bear the burden of showing, in advance of the treatment, that it offers a significantly less costly alternative that is substantially as effective. It is intended that "judiciousness" be established for specific treatments through scientific guidelines at the plan level, not through retrospective claims denial or through cost-benefit decisions by individual providers.

II. Treatments that are not medically appropriate shall be excluded from coverage.

Note: Plans should not be permitted to cover medically inappropriate treatments. Any additional resources should be devoted to improving the quality of covered benefits.

III. Treatments that are widely considered to be standard provider practice at the date of this Act shall be deemed to be medically appropriate unless found otherwise by the Secretary or until such treatments are no longer widely considered to be standard provider practice.

Note: This provision is intended to "grandfather" well-accepted treatments as covered benefits. The term "provider" is intended to reflect the fact that practitioners other than physicians may administer covered treatments. it is intended that plans desiring to exclude certain current treatments as medically inappropriate negotiate proposed exclusions with health alliances. For established plans, coverage of a service in the past should be considered good evidence of "standard practice." Over time, it is anticipated that clinical research will reveal certain existing treatments to be medically inappropriate.

IV. Medically appropriate treatments required to be administered in order to administer an investigational treatment in accordance with the design of an approved research trial in which such enrollee is participated shall be covered.

A. An "**investigational treatment**" is a treatment the effectiveness of which has not been determined.

B. An "**approved research trial**" is a trial, approved by the Secretary or her designee, conducted for the primary purpose of determining whether or not a treatment is medically appropriate.

Note: This provision is intended to require coverage of "routine medical costs" associated with the approved administration of an investigational treatment. An "approved research trial" may be conducted to determine safety, efficacy, or any other characteristic of a treatment which must be demonstrated in order for that treatment to be medically appropriate. Funding for investigational treatments and other issues involving clinical research are addressed elsewhere in this Act.

ATTACHMENT A

LIST OF INDIVIDUALS AND GROUPS WHOSE INPUT WAS SOUGHT REGARDING THE DEFINITION OF MEDICALLY APPROPRIATE:

LEGAL COUNSEL:

Walter Dellinger, Former White House Legal Counsel
and currently with the Justice Department
Jerry Klepner, Assistant Secretary for Legislation Designate, HHS
Harriet Rabb, General Counsel Designate, HHS
Marcy Wilder, NARAL
Congressional Legislative Counsel
Rosenberg and Kaplan, Beverly Hills
Sally Payton, Legal and Ethics working groups

LEGAL AUDIT GROUP

Lawyers and health law professors selected to audit our plan

ETHICS WORKING GROUP

Nancy Dubler
Norman Daniels
David Eddy
and others

PHYSICIANS

Bob Berenson, MD, Task Force
Bill Sage, MD and JD, Task Force
Michael Martin, MD, National Medical Audit
Arnold Milstein, MD, National Medical Audit
David Eddy, MD, Task Force

DISABILITIES CROSS CUTTING WORKING GROUP

Rick Brown, Task Force
Susan Daniels, Task Force
Simi Litvak, Task Force

CABINET MEMBERS

Carol Rasco, Domestic Policy Advisor to the President
Donna Shalala, Secretary of HHS

CONGRESSIONAL STAFF

Susan Wood, Congressional Caucus for Women's Issues
Robyn Lipner, Senator Mikulski and Senate Subcommittee on Aging
Mary Beth Fiske, Senate Committee on Labor and Human Resources
William Clark, Senator Bumpers
Karen Davenport, Senator Kerrey
David Nexon, Senate Committee on Labor and Human Resources
Dave Kendall, Rep. Andrews
William Olsen, Rep. Glickman
Peter Reinecke, Sen. Harkin
Julie Sochalski, Sen. Bradley

INTEREST GROUPS

Campaign for Women's Health
NARAL
Women's Legal Defense Fund
National Women's Law Center
Bass & Howes
Alan Guttmacher Institute
Planned Parenthood Federation of America
Older Women's League
Group Health of Puget Sound
Family Voices (Parents of disabled children)

WHITE HOUSE AND HHS STAFF

Ira Magaziner
Judy Feder
Chris Jennings
Atul Gawande
Melanne Verveer
Mandy Grundwald

WORKING GROUP #6 - BENEFITS COVERAGE

William B. Clark, Senator Bumpers
Karen Davenport, Sen. Kerrey
David Eddy, Task Force
John Edgell, Commerce

Marty Beth Fiske, Senate Cte. on Labor and Human Resources
Robert Gillingham, Treasury
Marthe Gold, PSH-OASH
Erik Johnson, OMB
David Kendall, Rep. Andrews
Robyn Lipner, Sen. Mikulski, Senate Committee on Aging
Michele Manowitz, Policy Assistant
David Nexon, Senate Cte. on Labor and Human Resources
Sheila Nix, Sen. Kerrey
William Olsen, Rep. Glickman
Peter Reinecke, Sen. Harkin
Bob Roswell, VA
Elmer Smith, HCFA,
Julie Sochalski, Sen. Bradley
Susan Wood, Congressional Caucus for Women's Issues
Robert Wren, HCFA

hold secret meetings" (Dana Priest, 5/1). The lower court had ruled that H.R. Clinton is not a federal employee or officer and thus must hold her meetings in public (Paul Bedard, WASH. TIMES, 5/1). Justice Dept. Attorney Mark Stern, representing Clinton, contends that "Official is probably the definition that fits her most comfortably." AP/DEMOCRAT-GAZETTE: "He cited a 1948 law in which Congress authorized appropriations for the 'spouse of the president in connection with assistance provided by such spouse in the discharge of the president's duties and responsibilities.'"

WORKING GROUPS EXEMPT?: POST: "Stern said the Clinton administration thinks the entire law governing advisory commissions is unconstitutional if it means that meetings of the task force's so-called working groups must be held in public. U.S. Appeals Judge Laurence H. Silberman noted that a district judge had ruled that the working group meetings could be closed, but he expressed amazement that the White House was willing to challenge the entire law, which was enacted as a post-Watergate reform" (Priest, 5/1). Silberman: "That would be a stunning assertion after all these years." However, Mr. Stern contends that "all task forces that offer substantial advice to the president should be allowed to meet in secret [and] ... only groups that provide several policy options should be required to hold public meetings -- not task forces that present a 'consensus' position or single option." While the judges indicated that the working groups should be subject to FACA requirements to meet in public since many members aren't fed. employees, task force director, Ira Magaziner maintains that "all working group members have been given special government employee status" (Bedard, WASH. TIMES, 5/1).

#3 ABORTION: GRUNWALD "STUN[S]" SENATORS ON ABORTION COVERAGE

N.Y. POST reports Pres. Clinton's "top media consultant," Mandy Grunwald, "stunned Democratic Senators" last weekend at a Senate retreat "by claiming the [WH] wants to avoid including abortion coverage in its health plan." POST: "Grunwald told the group last weekend the administration is afraid that including the coverage ... could doom the entire plan, sources said." According to a source at the meeting, Grunwald "said [the WH is] looking for ways to make sure [abortion] doesn't get tangled into the health care bill because it would have devastating political complications." Grunwald also "suggested states might be allowed to keep" current abortion funding rules. After Grunwald's comments, a "furious" Sen. Barbara Boxer (D-CA) "promptly stood up" and said, "I hope we're not gonna do that.'" According to the POST, Boxer met later with Hillary Rodham Clinton -- who "gave no definitive answer but took a pro-choice tone." Neither Grunwald nor Boxer "responded to repeated requests for comment" from the POST (Deborah Orin, 4/30).

HEALTH PLAN AT RISK?: Balto. SUN reports Pres. Clinton "could be putting the entire health reform plan at risk" because of proposals to include abortion coverage. The controversy lies in whether the basic package of benefits designed by the admin. -- to be subsidized by gov't funds for the unemployed -- should

include abortion coverage. Abortion opponents say polls show that while many Americans are tolerant of abortion rights, most oppose gov't funding for the procedure. Pro-choice advocates counter that the issue is "fairness: Poor women should receive the same benefits as women of means." Sen. Barbara Mikulski (D-MD): "It's now covered in the preponderance of private sector insurance and what we should be doing is staying the course." According to the Employee Benefit Research Institute, it is unknown how many private insurance plans cover abortion.

REAX: Dem pollster Celinda Lake: "I think it will be a major controversy, in part because there will be such strongly organized opposition." GOP pollster William McInturff: "There are Republicans who could be dragged into voting for reasonable health care reform. But once you start including financing for abortion, if you vote for something like that, you can guarantee in a Republican primary that for the rest of your life there's a chunk of people organizing against you." McInturff said pro-life Dems "who would probably support health reform ... would be 'substantially cross-pressured'" by pro-life constituents to vote against the plan. But Lake, Mikulski and NARAL's Kate Michelman say "once Americans understand" abortion coverage is a "medical issue ... they'll be generally supportive." Michelman: "You can't divide women into neat little categories and divide one reproductive health service from another."

GORE: SUN refers to a 1987 letter in which then Sen. Al Gore said he "consistently opposed federal funding of abortions." According to the SUN, Gore says he now supports Clinton's position on lifting the federal ban for abortion funding (John Fairhall, 5/1). NBC's "Meet the Press" with Tim Russert hosted Gore 5/2. Russert: "That's still your view, that ... federal funding for abortion should be included in a health care plan?" Gore: "I think the full range of reproductive services ought to be included in a health insurance program for those who want it" (5/2).

===== ELEMENTS OF REFORM =====

#4 THE PLAN: HILLARY MAKES A TRIP TO THE HILL

"Hillary Rodham Clinton tried [4/30] to signal a new bipartisan approach to health care reform, conducting a remarkable private briefing of Senate Democrats and Republicans on the administration's emerging plan," writes the N.Y. TIMES. During a two-and-a-half-hour meeting with about 52 senators, evenly split between parties, Clinton and WH advisers Ira Magaziner and Judy Feder "sketched out" the admin.'s proposals for a health system (Robin Toner, 5/1). WASH. POST reports the meeting "was meant to convey the message that the administration is willing to consult with Republicans before deciding on a finished plan -- a necessity driven home by the failure of President Clinton's stimulus package" (Dana Priest, 5/1).

PRICE CONTROLS: L.A. TIMES reports Clinton "disclosed that the administration is inclined to give medical providers a year or two to voluntarily restrict price increases, with a mandatory price freeze in the wings if voluntary efforts do not keep

Orthodox Jews with whom I prayed in the snow on Shabbat because they have no synagogue within which to meet.

The most significant meeting throughout this week of extraordinary experiences was an audience that five members of the American delegation—including the ecumenical officer of the Orthodox church in America, the Very Reverend Leonid Kishkovsky—had with the patriarch of Moscow, His Holiness Alexis II. The patriarch committed to us that he supports the principle of religious freedom, including equality of access by different religious groups within Russia, none of whom should suffer at the hands of the state. Neither does the Orthodox church seek a preferred or established position in a newly reconstructed state. Decades of the subversion of the church by the state would seem to counsel against that. And the patriarch described in painful detail the attempts of the state to destroy the Orthodox church in Russia, from the notorious five-year plan of Stalin in 1932 to Khrushchev's promise to eliminate Orthodox priests by 1988.

I recalled a bond of suffering between my people and his, going back to the period of the Penal Laws that imposed severe criminal penalties and civil sanctions on Catholics in England and Ireland from the Tudor period down to our own century. Remaining faithful under such circumstances as the Irish and the Russians have experienced is not easy, so I pledged the patriarch the constant support of my prayers for him and for the church in Russia. He thought this was the most important gift an American jurist could bring to Moscow.

EDWARD McGLYNN GAFFNEY, JR.

Edward McGlynn Gaffney, Jr., is the dean of the Valparaiso University School of Law.

WORLD WATCH

J. Bryan Hehir

HEALTH CARE FOR ALL

A CATHOLIC PERSPECTIVE

The Clinton administration's Task Force on National Health Care is scheduled to submit its report to the president this month. The report, of course, will be a proposal, and its publication will signal the beginning of a new phase of the national debate on health care. The U.S. argument about health care reaches back to the early 1970s, but the Clinton campaign and the Clinton presidency have generated new expectations for change, and its proposal for reform will provide a defined focus for the public debate. Among the institutions which are prepared by ideas and experiences to contribute to the national assessment of health-care reforms is the Catholic church. The church's participation in the policy process exemplifies the diverse dimensions of its public life. There will be space in the public argument for the church to act as a teacher, as a voice of public advocacy, and as an institution deeply involved in health care at the local and national levels.

These distinct roles correspond to the three major concerns which the church has in the U.S. health-care problem. The first is health care as a social justice issue, involving the question of access to health care available to the citizenry. The second is health care and medical ethics (or bioethics), involving a broad range of questions which have been traditional concerns of Catholic moral teaching. The third is the role of Catholic institutions as participants in the ministry of health care in the United States. What follows is an effort to describe the content of each of the church's interests and to highlight points of tension among these complex concerns.

A major part of the national debate in health care is focused on issues of social justice; at the heart of this policy question is the fact that close to 40 million individuals have no access to health insurance.

There are different ways to frame the social justice argument about access to health care, and some of the members of the Task Force are ethicists who have been arguing the justice case over the last decade. Using categories from Catholic social teaching to make the social justice case produces the following structure of argument. The first step is defining the right to health care; the right is a moral claim to a good (health care) which is essential to human dignity. The affirmation of the right finds concise expression in John XXIII's *Pacem in terris* (1963). While the right is declared, the papal text did not spell out the content of the right. Using the common logic of the social teaching, however, one could say that the right to health care should assure for each person a basic minimum of benefits which will vary with the economic capability of the society in which the right is being secured. In the U.S. debate, the church will have to engage the questions of universal access and the definition of which health-care benefits should fall within the category of minimum levels of care.

The assertion of each person's right to health care leads, secondly, to a determination of who has the duty to respond to the right. Here several elements of Catholic social thinking converge. The duty in the first instance falls on society as a whole; meeting the need for health care is an essential aspect of the common good. Society fulfills the responsibility to provide health care for each person through a multiplicity of agents. Catholic teaching on subsidiarity restrains the notion that the state should be the first agency to respond to the right; but the state clearly has moral responsibilities, and a major role

in meeting the health-care needs of the society. Both John XXIII's explanation of socialization in *Mater et magistra* (1961) and John Paul II's definition of the duties of solidarity in society establish the foundation for a positive and activist role for the state in responding to health-care needs.

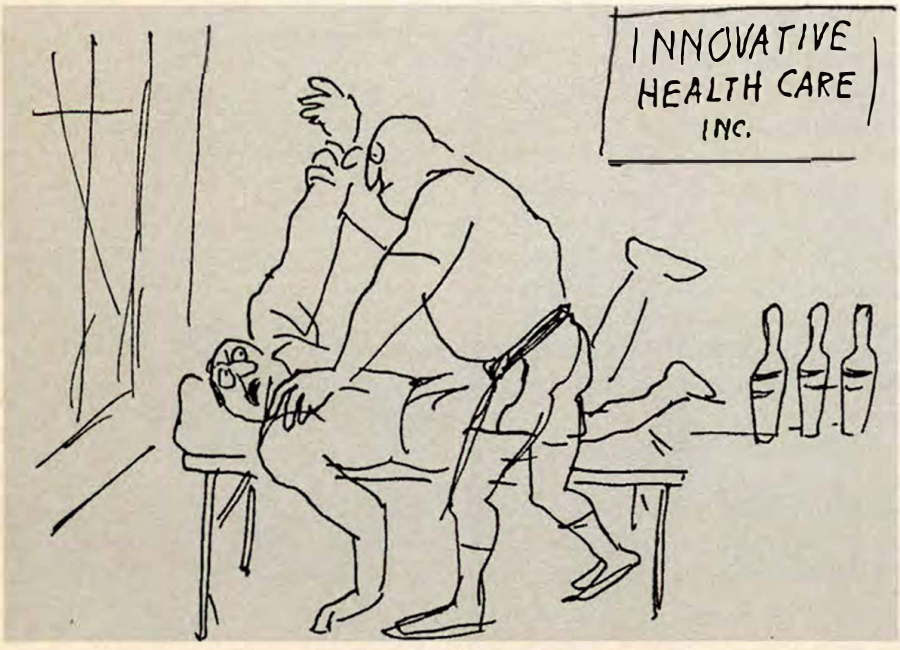
But subsidiarity encourages the search for other agents, "lesser than" the state, which also have obligations to meet the right to health care of each citizen. The health-care professions are the primary community upon whom the duty falls. In Catholic social thought a profession bears special social responsibilities. Professions are not to be conceived simply as interest groups or trade associations. Professions are accorded unique status in civil society, and they bear unique responsibilities. It is clear in the United States, as in all other postindustrialized societies, that the health-care professions cannot respond adequately to the need for universal access to health care without the extensive involvement of the state. But this fact should not obscure the primary role which the health-care professions still have in meeting health-care needs.

Between the state and the health-care professions in the United States stands another major actor, the health-insurance companies. While they do not have the moral role of a profession, health-care reform requires of these companies a conception of corporate moral responsibility which should be articulated and enforced through law and policy.

The architecture of the social justice case in Catholic terms, therefore, affirms a right to health care for all; includes meeting that right as an essential element of the common good; and identifies a mix of public and private actors which have duties to respond to the right. Catholic participation in the health-care debate will require going beyond these general statements to specify which benefits are required to fulfill the right, and how the diverse agents responsible for health care fulfill their different duties.

In engaging the social justice aspects of the health-care debate, Catholic teaching will complement and reflect other arguments in the public arena.

The Catholic case has a distinctive style, particularly the manner in which it joins the notions of subsidiarity, socialization, and solidarity; but the distinctiveness will create alliances with others. When the church raises its substantial and distinctive bioethical concerns, there will be clearer lines drawn between Catholic arguments and many who will support the Catholic social justice case on health care. The different reception likely to be accorded to the bioethical arguments is not a reason for submerging or forsaking them. The key issue, of course, will be abortion, particularly whether access to abortion will be included in the Clinton proposal for a basic package of benefits. There also may be issues which bear upon care of terminally ill patients. To fill out the agenda, it should be noted that Catholic health-care facilities have long struggled with the issues surrounding contraception and sterilization.



"Easy on the innovation, damn it!"

It is clear that the church's involvement in the health-care debate must include both social justice and bioethical issues. The key need is for an overall strategy to relate these two areas. At this stage of the public debate I propose two moves. First, following the style of Vatican II's *Gaudium et spes*, as well as older Catholic arguments about public vs. private moral issues, the strategy should distinguish the "public issues" of abortion and care of the terminally ill, from "private issues" of contraception and sterilization. The public issues are concerns which affect the public order of society because they can involve taking human life. The church should undoubtedly try to shape the health-care legislation in a way which sets standards on these issues for society as a whole. The private issues should be addressed only to the extent that institutional conscience clauses will protect Catholic facilities. In effect, we should not expect to find the private issues resolved in the legislation in a way which follows Catholic teaching. (I say this while acknowledging that aspects of sterilization policy could qualify it as a public issue. There is, however, no public consensus to support this idea.)

Second, the church can make "public arguments," i.e., not a specifically Catholic case, to oppose abortions as part of a benefits package. The U.S. Catholic Conference has already taken such a position, arguing that the inclusion of abortion in the benefits package would be "a moral tragedy, a serious policy misjudgment, and a major political mistake." This position has solid warrants to recommend it; including abortion in a federally financial heath-care plan would be a major shift in using tax monies to support a highly contested issue of conscience in the country. The church can sustain a difficult but

credible moral posture in the public debate by joining strong support for health care on social justice grounds and strong opposition to abortion. The case is morally coherent, but it will be very difficult to prevail in the present climate on abortion. It is clearly worth a major effort. The case should be cast in justice terms across the two issues: what justice demands for unborn life, and what it demands to protect life after birth.

Clearly at this moment the best creative energies in the church should be devoted to joining these two kinds of justice claims. Some energy must also be used to think through the relevant moral categories of law and morality, material cooperation, and the full range of conscience clause protections which will be needed to shape a Catholic strategy if we do not prevail on both sides of the justice argument.

Finally, in the public debate the Catholic case for health care should include a strong argument for the value of a pluralistic health-care system. Pluralistic in this setting means a system of public and private institutions, as well as institutional protection for specific religiously based policies. Along with protecting social justice and justice as a right-to-life claim, the argument for pluralism is the other major piece of the Catholic case in the health-care debate. Few other institutions will carry as complex a case in the legislative struggle we are now facing as a nation. □

OF SEVERAL MINDS Abigail McCarthy

GOODFELLOWS

REINVENTING GOVERNMENT

One of the aims of the new administration, we have been assured, is to increase citizen participation in government—part of the process of "reinventing government." For that reason a director of national service, Eli Segal, long an associate of the president's, is a prominent member of the White House staff.

Various unhappy old-timers have pointed out that effective agencies for participation are already in place—among them, of course, the Peace Corps, VISTA, SCORE (the senior corps of retired executives connected with the Small Business Administration), and the White House Fellowships.

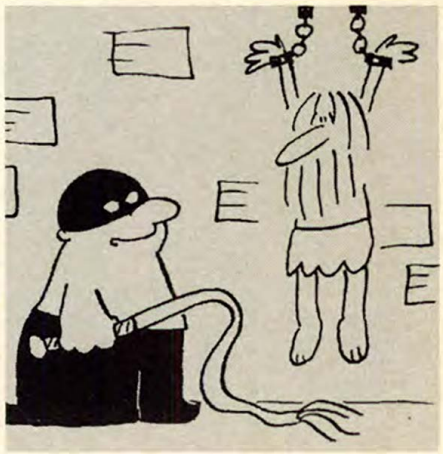
The White House tendency toward duality is apparent here. At the State Department, the new "czarship" for relations with the varied new governments of the separated parts of the former Soviet Union might seem to be at odds with the European desk. The Clinton people think otherwise and have set about putting their appointees in charge of both old and new. Apparently the newly created agencies are intended to provide competitive stimulus to the established ones.

One of the least known of the agencies for increased citizen participation is the President's Commission on White House Fellowships. Brooke Shearer, a long-time FOB (Friend of Bill's) who accompanied Hillary Rodham Clinton on the campaign trail, is the newly appointed director. According to her, the fellowships were the unlikely fruit of the Vietnam War. They were instituted during the Johnson administration to counteract the rising tide of distrust of government at that unfortunate time.

The creation of the fellowships was the idea of John W. Gardner, former secretary of Health, Education, and Welfare, and Fellowship Commission chairman, 1977-81. Gardner, readers may remember, was the epitome of those from American "good families" who saw public service as both an obligation and an honorable profession. (It was he who also founded Common Cause, the organization which sought to enlist citizens nationwide in affecting the legislative process through citizen lobbying.) His statement about the White House Fellows is typical of his idealistic approach to public service in a democracy:

> Our founding fathers all came from villages or the countryside, or from what would now be regarded as very small cities. All of them had the opportunity, as youths, to see at first hand the process of governing.
>
> Today young people of comparable ability grow up in a huge, complex, noisy society, and almost none gets a close-up view of government. The White House Fellowship Program is one attempt to deal with that unfortunate fact.
>
> Each year a selection of the most promising young men and women in America are given the opportunity to see and participate in the process of governing at the highest levels.
>
> As the years go by they have become a growing reservoir of exceptional individuals prepared to serve their country.

When Gardner broached the idea, it was warmly welcomed by then President Lyndon Johnson and Lady Bird Johnson, according to Brooke Shearer. (It is interesting to note that Shearer's phrasing, "Lyndon *and* Lady Bird," although undoubtedly apt, is more typical of the Clinton White House than of the preceding ones.) But Gardner's original proposal that there be a hundred of the fellows assigned throughout the executive branch was pared down sharply. The numbers of



"I got into government service because I wanted to help people."

fellows have ranged from eleven to nineteen. One can speculate that in the climate of the Johnson administration and the '60s, the prospect of spreading 100 of those thirty-years-old or under throughout the government might have seemed risky indeed.

It is also interesting to note that the criteria for eligibility established in the Johnson era excluded all employees of the federal government *except* career military personnel.

The fellows, although young, are in the early or formative years of their careers or professions, and, in the words of the recruitment brochure, "have contributed to their communities—geographic or professional. This leadership and commitment to their communities is a vital element in the commission's criteria for selection."

What do they do in their fellowship year? They are full-time Schedule A employees of the federal government, working in the executive office of the president or in an executive department or agency. They are told that "although White House Fellows will draw on specific prior training, education, and experience, they should not expect to continue doing the type of work they had been doing before entering the program. An attorney may spend a large part of his or her year working on arms control and disarmament issues. A businessman may spend a year working on welfare reform. A physician may take the lead in establishing a pilot exchange program with a foreign government."

The brochure states that most fellows return to their geographic, or at least professional communities "where they can share their new knowledge and contribute to society more productively through a fuller understanding of the federal government." But more than a few have returned to government—among them Henry Cisneros, former mayor of San Antonio, and now member of the Clinton cabinet as director of Housing and Urban Development, and former Senator Tim Wirth, another Clinton appointee.

There have been twenty-eight classes of fellows since the program's inception. The list of alumni is impressive indeed. It includes General Colin Powell and the commanders of the Atlantic and Pacific fleets, Admirals Leon Edney and Charles R. Larson. It includes also various officers of corporations, among them Tom Johnson, president of Cable News Network, a member of the first class; Dana Mead, president of Tenneco; and Michael H. Walsh, CEO of Tenneco.

But most of them, it seems to me, have become members of the establishment. They are leaders, true, but few have been agents of change. (Among those cited to me only one seemed to be clearly that—Anne Cohen Donnelly, director of the public interest group, the National Commission for Prevention of Child Abuse.) Representatives of the creative arts are also few. This may be the result of the selection process: The standards are set by the commission, which is appointed by the president and, for most of the years of the fellowships' existence, that president has been a Republican. Members of the regional interviewing panels are "leading citizens" also appointed by the president via the commission.

The results of the process have been predictable. In the 1992-93 class, for example, there were two women—one a professor at West Point, and one a former police officer. There were two blacks—both majors–one in the Army, the other in the Air Force. There were two other career military officers, three lawyers from top firms, three officers from financial companies, one CEO of a restaurant chain, one doctor, one associate professor. These may or may not be members of "the growing reservoir of exceptional individuals prepared to serve their country," but in Clintonian terms, they certainly do not mirror America.

So far Brooke Shearer's plan for reinventing this small government program aims at broadening the spectrum of occupations from which the fellows are drawn. The steps toward the doing of that, it would appear, should include changing the commission and the selection panels, as well as dealing with the alumni fellows who in large part fund the program through private contributions to the White House Fellows Foundation—in other words, a thorough restructuring.

Reinventing government will not be easy. □

THE WHITE HOUSE

WASHINGTON

'93 SEP 20 P7:31

September 21, 1993

MEMORANDUM FOR THE PRESIDENT

FROM: **BILL GALSTON** WAG

SUBJECT: **EFFECT ON THE STATES OF DELETING THE HYDE AMENDMENT**

In the briefing this afternoon prior to your meeting with the Democratic women senators, you posed a question concerning the impact on the states of repealing the Hyde amendment. Time did not permit a full answer, but I thought it was important that you have the opportunity to review it now. I want to emphasize, however, that the following discussion is purely hypothetical, because there is at present no practical possibility that the Hyde amendment would be defeated in a straight up-or-down vote.

Prior to the adoption of the Hyde amendment in 1976, various states were grappling with the issue of what they were required to do under the Medicaid law. Litigation on this point was headed toward the Supreme Court but became moot after the passage of the Hyde amendment. In Harris v. McRae (1980) the Court upheld the Hyde amendment and ruled that the states themselves were not obligated to cover medically necessary abortions in the absence of federal funding. In an earlier decision, however, the Court noted that without the Hyde amendment in place "serious statutory questions might be presented if a state Medicaid plan excluded medical treatment from its coverage" (Beal v. Doe, 1977).

As you can see, the position of the Court to date has been less than crystal-clear. Both OMB and the General Counsel's office at HHS believe that in the absence of Hyde, it would be most reasonable to construe the Medicaid statute as requiring states to provide funding for medically necessary abortions. It does not follow, however, that states would in practice be compelled to do so.

In the first place, the meaning of the phrase "medically necessary" has never been litigated--as it certainly would be if Hyde were deleted and the states came under the full force of the Medicaid law.

Second, a state would certainly not be required to fund abortion procedures forbidden under a generally applicable state law that passes constitutional muster.

We will keep on working to further clarify this issue.