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THE WHITE HOUSE

WASHINGTON

May 24, 1999

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings
Mary Beth Cahill
Jenny Luray

SUBJECT: Impending Introduction of Contraceptive Coverage Legislation

We expect a bipartisan group of Congressional members to introduce the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC) shortly after the Memorial Day recess. The legislation would require health plans to cover prescription contraceptive coverage if they cover other prescription drugs; it is generally consistent with the measure you signed into law last year mandating such coverage in all plans participating in the Federal Employees Health Benefits Plan (FEHBP). This memorandum provides background information on this issue and seeks guidance as to whether you want to endorse the bill when it is introduced.

BACKGROUND

Current Coverage Status. While well over 80 percent of private insurance plans cover prescription drugs in general, only about one-third cover the costs of oral contraceptives (the most commonly used birth control method). HMOs provide slightly better oral contraceptive coverage but only 39 percent cover all five leading methods. According to the Kaiser Family Foundation, three out of every four women say that cost is an important factor when choosing between a birth control method that is covered and one that is not. Moreover, women of childbearing age spend 68 percent more in out-of-pocket health care costs than men do, although there is no specific breakout as to what percentage is for contraception.

EPICC Legislation. EPICC was first introduced in the last Congress by Senators Reid and Snowe and Representatives Lowey and Greenwood. This legislation would require insurance plans to cover all FDA approved forms of contraception if and to the extent that they cover other prescription drugs. The bill also would require plans to provide outpatient contraceptive services (such as exams and fittings) in the same manner as they cover other outpatient medical services. Similar legislation has been introduced in 19 states in the last two years, and Maryland and Georgia recently became the first states to enact such laws.

When it became clear that this legislation could not be passed last year, EPICC's sponsors focused their attention on working on encouraging the Congress to extend these protections to FEHBP plans. After a lengthy fight over "conscience clause" language, Congresswoman Lowey -- with the

help of the Administration -- secured passage of the FEHBP provision in the Omnibus Appropriations measure you signed last fall. Leading women's groups and the pro-choice community hailed this as a major victory. The same group of supportive Members, along with supportive women's and pro-choice groups are now turning their attention to winning contraceptive coverage for those in all private plans.

Policy Arguments for EPICC. The women's and pro-choice communities believes that EPICC provides an all-too-rare opportunity to promote a positive agenda. Better contraceptive coverage means fewer unintended pregnancies, which means fewer abortions. For this reason, EPICC is now a top legislative priority for many of the leading women's and pro-choice organizations.

Endorsing this legislation would be consistent with your past position on FEHBP and would once again position us on a women's health issue that has strong policy rationale. It strengthens our hand on the pro-choice agenda and would be extremely well received by the women's advocacy community. Just as important, your endorsement would make a substantive contribution towards increasing the likelihood that this legislation would pass the Congress this year.

Mandates and Potential Impact on Cost/Coverage. We generally have avoided endorsing bills that impose insurance coverage requirements -- particularly when they are initially introduced. We have taken this position for two reasons: (1) to avoid the criticism that such "rifle shot" requirements increase premiums and thereby increase the number of uninsured and (2) to avoid starting down the slippery slope of supporting a slew of other insurance requirements.

As you know, you already support the Patients' Bill of Rights legislation, which although mostly requiring procedural rather than coverage requirements, is projected by CBO to increase premiums by about 4 percent). In addition, you have been asked to support legislation to impose further coverage requirements for mental health and substance abuse treatment and to assess a 1 percent premium fee on private plans to help finance the cost of training physicians in teaching hospitals and academic health centers. Although EPICC is projected to add only 1 percent to average private sector premiums, the accumulation of these policy initiatives could make us vulnerable the criticism that we are decreasing the affordability of insurance.

Conscience Clause Issue. One notable shortcoming of the current EPICC bill is that it does not include a "conscience clause" for plans that have religious objections to providing contraceptive coverage. Although the bill's sponsors and the pro-choice community recognize that this issue will have to be addressed before any bill reaches your desk, they oppose including any "conscience clause" language at the time of introduction. They are taking this position for two main reasons. First, they believe that the "conscience" problem is not as great in the context of contraception as in the context of abortion. Second, they believe that adding such language could leave too many women without access to contraceptives in light of Catholic-affiliated providers participating in the managed care market. The sponsoring members and groups would rather deal with this issue as and when it arises than introduce a bill that they believe already represents a significant compromise.

We believe that the advocates' position on this matter is mistaken, and that it is important to signal up-front an explicit commitment to accommodate plans with religious scruples. To omit it makes advocates vulnerable with respect to an issue that they will lose in the end. In addition, omitting conscience language makes the bill supporters vulnerable to a "double-standard" charge; they are willing to support such language when it applies to the Congress and federal health plans, but not when it applies to health plans in the private sector. The sponsoring members and groups, however, have rejected our advice on this issue.

OPTIONS

The following are the most viable options for your consideration:

(1) **Issue a statement of support for the new legislation, but do so in a manner that subtly signals your willingness to work on conscience clause language.** Under this scenario, you would release a statement at the time of introduction that notes your support for similar legislation last year and calls on the Congress to take further action, applying to private health plans, on this high priority issue. Such a statement would imply support for a conscience clause (since last year's bill had one), but would not offend the pro-choice community at the time of introduction.

(2) **Not endorse this legislation, but work behind the scenes to get legislation passed with an appropriate conscience clause.** Under this approach, you would take no formal position at the time of introduction, but advise the pro-choice community that we will provide technical and strategic support to pass this bill on Capitol Hill. Such an approach would allow you to avoid criticism relating to the cost of imposing insurance mandates and also would allow us to develop a workable conscience-clause compromise.

White House and Agency Positions on These Options. DPC, the Women's Office, the Office of Public Liaison, and OMB support option one. Although believing that the pro-choice community is making a significant error by not including a conscience clause provision in the bill at the time of introduction, these offices believe we should respond positively to the women's community on this key legislative priority and provide momentum to a bill guaranteeing equity for women at a low cost. In addition, these offices believe that the Administration should provide early support for this positive, proactive message on choice. HHS believes that this decision depends on whether you are likely to endorse other coverage mandates (like mental health parity) in the near future (like mental health parity); if you are, they would support option 2 because the cumulative impact of these endorsements will undermine our credibility on the cost/coverage issue.

Option 1: _____ Option 2: _____ Let's Discuss: _____

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Contraception

TO: Hillary Rodham Clinton
Melanne Verveer
FROM: Jennifer Klein J.K.
DATE: 9/8/97
RE: Abortion Data

Following discussions about whether the Administration should support legislation requiring insurance companies to cover contraception, you had asked for information about the age and insurance status of women who have abortions. There are no data on how many women who have abortions have health insurance or use insurance to pay for an abortion. I have attached a chart on the ages of women who have abortions. According to the CDC's Abortion Surveillance, girls under 15 have the greatest rate of abortions. Because many girls under 15 are covered by their parents insurance plans (if they have coverage), requiring insurance companies to cover contraceptives is not likely to affect whether or not these girls get abortions.

I also looked into health insurance coverage of contraception. Forty-nine percent of all traditional fee-for-service plans do not cover any contraceptive methods, and only 15 percent cover the five most commonly used contraceptive methods (oral contraception, IUD, diaphragm, Norplant and Depo-Provera injection). Oral contraception, the most commonly used method in the United States, is covered by only 33 percent of plans. By contrast, 97 percent of these plans cover other prescription drugs. Health maintenance organizations offer more complete coverage. Ninety-three percent cover some contraceptive method, although only 39 percent cover the five most commonly used methods. Oral contraceptives are covered by 84 percent of HMOs, a rate almost equal to their coverage of prescription drugs.

It is also worth noting that while the number of abortions has been declining consistently over time, the number declined significantly during the Clinton Administration, particularly between 1993 and 1994.

Table 15. Legal abortion ratios, according to selected patient characteristics: United States, selected years 1973–94

[Data are based on reporting by State health departments and by hospitals and other medical facilities]

Characteristic	1973	1975	1980	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
						Abortions per 100 live births[1]							
Total	19.6	27.2	35.9	35.4	35.4	35.6	35.2	34.6	34.5	33.9	33.5	33.4	32.1
Age													
Under 15 years	123.7	119.3	139.7	137.6	116.3	127.5	94.9	88.6	84.4	76.7	79.0	74.4	70.4
15–19 years	53.9	54.2	71.4	68.8	65.0	66.8	62.4	56.0	51.5	46.2	44.0	44.0	41.5
20–24 years	29.4	28.9	39.5	38.6	38.0	38.6	37.4	36.6	37.7	37.8	37.6	38.4	36.4
25–29 years	20.7	19.2	23.7	21.7	22.1	21.8	21.4	21.1	22.0	22.1	22.2	22.7	22.2
30–34 years	28.0	25.0	23.7	19.9	19.8	19.6	18.8	18.7	19.1	18.7	18.3	18.0	17.2
35–39 years	45.1	42.2	41.0	33.6	31.3	29.7	28.0	27.1	27.3	26.2	25.6	24.8	23.4
40 years and over	68.4	66.8	80.7	62.3	59.0	55.5	51.4	49.6	50.1	46.9	45.4	43.0	41.2
Race													
White[2]	32.6	27.7	33.2	27.7	26.9	26.7	25.9	25.2	25.8	24.6	23.6	23.1	21.7
Black[3]	42.0	47.6	54.3	47.2	48.8	50.0	48.9	49.6	52.1	50.2	51.8	52.9	51.6
Hispanic origin[4]													
Hispanic	---	---	---	---	---	---	---	---	---	30.0	30.7	28.8	27.9
Non-Hispanic	---	---	---	---	---	---	---	---	---	33.2	32.6	31.0	29.4
Marital status													
Married	7.6	9.6	10.5	8.0	10.2	9.6	8.8	8.1	8.9	8.9	8.4	8.4	7.9
Unmarried	139.8	161.0	147.6	117.4	95.8	101.9	102.7	92.1	87.9	81.5	79.0	78.9	68.9
Previous live births[5]													
0	43.7	38.4	45.7	45.1	41.5	41.0	37.7	36.8	35.8	34.8	32.7	32.4	30.9
1	23.5	22.0	20.2	21.6	21.5	22.2	21.8	21.2	23.0	23.2	22.9	23.1	22.3
2	36.8	36.8	29.5	29.9	30.5	31.5	30.4	28.9	31.7	31.9	31.9	32.2	30.9
3	46.9	47.7	29.8	18.2	29.7	30.9	29.1	26.5	30.2	31.0	30.8	31.5	30.8
4 or more[6]	44.7	43.5	24.3	21.5	22.4	24.7	21.9	22.3	27.1	22.6	25.5	23.4	23.3

--- Data not available.

[1]For calculation of ratios according to each characteristic, abortions with the characteristic unknown have been distributed in proportion to abortions with the characteristic known.

[2]For 1989 and later years, white race includes women of Hispanic ethnicity.

[3]Reported as black and other races before 1989.

[4]Includes data for 20 States, the District of Columbia, and New York City in 1991–94. States with large Hispanic populations that are not included are California, Florida, and Illinois.

[5]For 1973–75 data indicate number of living children.

[6]For 1975 data refer to four previous live births, not four or more. For five or more previous live births, the ratio is 47.3.

NOTES: For each year since 1969 the Centers for Disease Control and Prevention has compiled total abortion data from 50 States, the District of Columbia (DC), and New York City (NYC). The number of States reporting each characteristic varies from year to year. For 1992–94 the number of States reporting each characteristic was as follows: age, 41–42 States, DC, and NYC; race, 34–35 States, DC, and NYC; marital status, 35–37 States, DC (in 1992), and NYC; previous live births, 36–38 States and NYC.

SOURCES: Centers for Disease Control and Prevention: Abortion Surveillance, 1973, 1975, 1979–80. Public Health Service, DHHS, Atlanta, Ga., May 1975, April 1977, May 1983; CDC Surveillance Summaries. Abortion Surveillance, United States, 1982–83, Vol. 36, No. 1SS, Public Health Service, DHHS, Atlanta, Ga., Feb. 1987; 1984 and 1985, Vol. 38, No. SS–2, Sept. 1989; 1986 and 1987, Vol. 39, No. SS–2, June 1990; 1988, Vol. 40, No. SS–2, July 1991; 1989, Vol. 41, No. SS–5, Sept. 1992; 1990, Vol. 42, No. SS–6, Dec. 1993; 1991, Vol. 44, No. SS–2, May 1995; 1992, Vol. 45, No. SS–3, May 1996; 1993 and 1994, forthcoming.