Reproductive Health Services and Expansion of Religious Health Entities: Bill Introduced in CA to Ensure Access

May 1999

The first of its kind in the nation, AB 525 was introduced in the California legislature by Assembly Members Sheila Kuehl and Helen Thomson. AB 525 is meant to preserve access to reproductive health services in the rapidly changing health care market place. In California and around the nation, religious health systems are the fastest growing hospital systems. Catholic hospitals, in particular, are gaining significant influence in the health care market [see box on next page]. As with most other hospital mergers, local communities are excluded from negotiation discussions and have access to very little information until the deals are almost completed.

Catholic hospital mergers with non-sectarian entities endanger access to reproductive health services. Catholic hospitals must abide by the *Ethical and Religious Directives for Catholic Health Care Services* ("*Ethical Directives*"). Under the *Ethical Directives* Catholic health entities are prohibited from providing a broad range of reproductive health services – contraception including tubal ligations and vasectomies), distribution of condoms to combat the spread of HIV/AIDS, abortions, emergency contraception for victims of rape, and infertility treatments.

The manner in which the *Ethical Directives* are applied varies from hospital to hospital and community to community. Decisions about what reproductive health services are available and how they are accessed often are made in consultation with the local Bishop. Thus, some Catholic hospitals may ban all reproductive health services and others offer only some services.

The impact of religious health mergers on access in local communities has been formidable. According to Catholics for a Free Choice (CFFC), there have been 127 consolidations between Catholic and non-Catholic hospitals since 1990. CFFC has obtained information on 100 of them, finding that in 48 percent of the deals, all or some reproductive services have been eliminated.[1]

This also poses a problem for women in managed care plans who are locked into a network of providers. In Fresno County, California, for example, a county employee was not able to obtain a tubal ligation through her health plan because the health plan contracts only with a Catholic hospital. Even though the tubal ligation is covered by her county health insurance, she had to go out of plan and use other resources to access the service that she needed.

While women in Medicaid managed care plans have the right to go out-of-plan for family planning, the right is illusory unless they are told of the right and have accessible out-of-plan providers who can furnish these services. Access to out-of-plan services also does not help when a low-income woman wants to obtain a voluntary tubal ligation at the time of labor and delivery. While the tubal ligation is available at an out-of-plan hospital, labor and delivery generally are not. This means that a woman must first deliver her baby, then pursue a second procedure later.

Making the situation more complex is the fact that Catholic entities historically have served low-income and rural areas. Local communities continue to perceive religious entities as overwhelmingly serving the poor and providing charity health care services. As such, communities often believe that they must choose between indigent care and women's health services.

Moreover, communities believe that religious health entities are more worker-friendly and support labor unions. With the increasing pressures of managed care and a more consolidated market place, religious health entities currently may not be providing any more indigent care,[2] and may not necessarily be more supportive of their employees than any other nonprofit or for-profit entity.[3]

Community members are learning, however, that it is necessary to challenge assumptions and perceptions about any entity -- for-profit or nonprofit, sectarian or nonsectarian -- with respect to indigent and emergency care, labor relations, and reproductive health. With community involvement, creative solutions have been devised to preserve access to services for all members of the community, men and women alike.

For example, in Battle Creek, Michigan, when a Catholic and non-Catholic facility merged, they created a separately-operated "condominium hospital" with an operating room and four beds on the top floor of the facility. With its own corporate structure, financing, board and staff, the mini-hospital is not bound by the *Ethical Directives* and can provide hospital-based reproductive health services.[4]

In Santa Maria, a rural community in Central California, a Catholic entity owns and/or operates a hospital and two community clinics. Tubal ligations, emergency contraception, family planning, and abortion were not offered. In addition, the only other hospital in the community, a nonsectarian hospital, was shutting its doors and leasing the facility to the Catholic hospital. This meant that reproductive health services would be severely limited in the community.

With the assistance of the Advocates for Reproductive Choice in Health Care (ARCH) Project,[5] local advocates and community members organized a community forum to address the hospital closing and the lease agreement. Representatives from the hospital were invited to participate. Overwhelmingly, community members raised concerns about access to reproductive health care. The local community response prompted the hospital to agree to provide tubal ligations at the hospital and to discuss allowing the county to provide family planning at its clinics. Time and again, community involvement has proved key to maintaining access to reproductive health care.[6]

AB 525, the first bill in the country to address this issue, was introduced in the California legislature to ensure that community members have tools to voice their concerns and to preserve access to services. Specifically, AB 525 will:

- Require health plans (including Medicaid and commercial HMOs) whose providers restrict access to reproductive health services to contract with at least one other facility within the same geographic area that provides those services.

- Require health plans to inform consumers up front of any restrictions to reproductive health services imposed by health entities in their network.
- Give the California Attorney General new powers and clarifies current authority to oversee nonprofit-to-nonprofit hospital mergers and to determine whether the merger will have a negative impact on patient access to reproductive health services, indigent care, and emergency care. The bill also brings these negotiations out into the open by requiring a public process.
- Require hospitals and other health care providers who seek taxpayer dollars through public bonds and loan guarantees to demonstrate how reproductive health services will be available in the local community, either by providing services or by partnering with others who will.
- Prohibit discrimination on the basis of race, color, religion, national origin, gender, or sexual orientation in the availability and type of health insurance coverage offered by indemnity plans, commercial HMOs, and Medicaid managed care plans.

As the first of its kind in the country, AB 525 has raised debate on the free exercise of religion by religious health entities, the religious freedom of community members, individuals' Constitutional right to reproductive health services, and the state's compelling interest in preserving access to health care. It is not without controversy. However, it is an important first attempt to balance these issues and merits close monitoring by health and women's advocates.

The California Women's Law Center and NHeLP are cosponsors of the bill. The bill language and information on the status of the bill can be accessed through NHeLP's website at http://www.healthlaw.org.

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1 Catholics for Free Choice, Caution: Catholic Health Restrictions May Be Hazardous to Your Health at 5 (1999).

2 *See, e.g.*, Monica Langley, *Nuns' Zeal for Profits Shapes Hospital Chain, Wins Wall Street Fans*, Wall St. J., Jan. 17, 1998 at A1.

3 *See, e.g.*, McKeon v. Mercy Healthcare Sacramento, 19 Cal. 4th 321 (1998) (Catholic hospital successfully arguing to the California Supreme Court that it could not be held liable for race and gender discrimination under state law, because it is a religious organization); *Church Hospital Challenges Labor Law*, S.F. Chron., Oct. 29, 1998, at B1 (Adventist hospital argued before the National Labor Relations Board that it should not be required to honor a vote by the nurses to unionize because "the self-sacrifice required for its healing mission is inherently incompatible with the economically self-serving goals of unions")

4 Merger Watch, Religious Hospital Mergers and HMOs: The Hidden Crisis for Reproductive Health Care at 20 (1997-98).

5 The ARCH Project is a collaboration between the California Women's Law Center and the National Health Law Program. For more information, contact Susan Fogel, CWLC, at (213) 637-9900 x 204 or Lourdes Rivera, NHeLP, at (310) 204-6010.

6 *See e.g.,* Deanna Bellandi, *Okla. Hospitals Won't Build Women's Facility*, Modern Healthcare, March 15, 1999, at 24 (community blocked building of women's health center that would not provide tubal ligation. The health center was a collaborative project between St. Mary's Mercer hospital and Integris Bass Baptist Health Center, both of which would have closed their obstetric departments once the Center had been built. However, Integris had agreed to ban tubal ligations in deference to St. Mary's. St. Mary's claims that financial considerations, and not community opposition, were the primary reason for canceling the project).