SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based only on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 1160

SPONSOR: Banking and Insurance Committee and Senator Kurth

SUBJECT: Equity In Contraceptive Coverage

DATE: April 19, 1999 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Woodham	Deffenbaugh	BI	Favorable/CS
2.	Hendon	Hadi	FP	Favorable
3.				
4.				
5.				

I. Summary:

The Committee Substitute for Senate Bill 1160 creates the "Equity in Prescription Insurance and Contraceptive Coverage Act." Currently, many insurers in Florida do not reimburse for the cost of contraceptives on the same level as other prescription drugs. The bill requires any individual, group, franchise, accident, or health insurance policy or health maintenance contract which provides coverage for outpatient prescription drugs to also cover prescription oral contraceptives approved by the federal Food and Drug Administration and prescribed by a licensed medical practitioner. The bill provides for coverage of oral contraceptives, and that the coverage be provided to the same extent and subject to the same contract terms, including copayments and deductibles, as any other prescription drugs. The bill contains a specific exclusion for coverage of chemically induced abortions.

The Committee Substitute for Senate Bill 1160 provides that a religious health plan sponsor, including but not limited to any church, religious school, religious association, or other religious organization which is not organized for private profit, will not be required to provide coverage for oral contraceptives which are contrary to the religious tenets of the religion or religious group. The bill defines the term "religious health plan sponsor" by referring to the federal definition of "church plan" set out in the Employee Retirement Income Security Act of 1974.

This legislation may result in increased costs for state and local government providers of employee health benefits. According to the Division of State Group Health Insurance, enactment of this legislation will not effect its HMO providers, as they currently provide coverage for oral contraceptives. However, the state PPO provider will experience increased annual costs between $2.3 and $3.8 million. Medicaid already provides coverage for oral contraceptives, so no increased cost will be incurred.

This bill creates the following sections of the Florida Statutes: 627.64061, and 627.65741. This bill amends the following sections of the Florida Statutes: 641.31, 627.6515, 627.6699.

II. Present Situation:

Contraceptive Coverage for Women

While most employment-related insurance policies in the United States cover prescription drugs, many plans exclude coverage from prescription contraceptive drugs or devices. Insurance companies explain that the reason coverage is not extended to contraceptive drugs or devices is that the purpose of medical insurance is generally to cover illnesses, disabilities, and physical dysfunctions. Drugs, devices, or other contraceptive methods used for the purpose of family planning are generally outside the scope of medical care, from an insurance perspective. Insurance companies further suggest that mandated contraceptive coverage would increase the cost of premiums and may force small business owners into dropping their insurance plans completely.

In 1998, bills mandating contraceptive coverage were introduced in 18 states. In April of 1998, Maryland became the first of these states to pass such legislation. The Maryland law includes a conscience clause that permits a religious organization to obtain an exemption if providing contraceptive services conflicts with its religious beliefs and practices. Six other states--Hawaii, Montana, New Mexico, Texas, Virginia, and West Virginia--have some legal requirement for insurance coverage of contraceptives. Hawaii and Virginia require insurers to offer coverage to employers, and Montana, New Mexico, Texas, and West Virginia require at least some insurance plans to cover contraceptive care.

Legislation requiring contraceptive coverage passed at the federal level in 1998. The Omnibus Federal Budget Act includes a provision that requires federal employee health insurance plans to cover prescription contraceptives if the plan pays for other drugs. The federal law provides exemptions for religious-affiliated plans and doctors with moral objections.

In its 1999 legislative session, Georgia passed legislation similar to the proposed bill, requiring insurers to provide coverage for any prescription drug or device approved for use as a contraceptive. The bill has not yet been signed by the governor.

According to the American College of Obstetricians and Gynecologists, 90% of health plans cover prescription drugs and devices, but only 49% of indemnity plans cover the five most commonly prescribed reversible methods of conception. These five methods include: birth control pills, Depo Provera, Norplant, the intrauterine device, and the diaphragm. Contraceptives are often covered when used for purposes other than for birth control. Doctors prescribe birth control pills for several conditions, including prevention of ovarian cancer, management of painful or heavy menstrual periods, symptoms of menopause, and endometriosis, a painful disease in which the uterine lining grows outside the uterus.

Close to 50% of all pregnancies in the United States are unintended, and half of all unintended pregnancies end in abortion. A 1994 Florida study showed that 45.8% of pregnancies in Florida were unintended, and 24% of those unintended pregnancies ended in induced abortion. Proponents of legislation calling for contraceptive coverage argue that contraceptives are proven to prevent unintended pregnancies and, as a result, reduce the number of abortions. California research shows that access to contraceptives reduces the probability of having an abortion by 85%.

Proponents also suggest that providing a policyholder with a monthly supply of birth control pills will cost insurance companies much less than the cost for prenatal care and delivery charges resulting from a woman's unintended pregnancy. They assert that more effective contraceptive use may translate into fewer unintended pregnancies, which in turn results in lower pregnancy related costs. It is estimated that contraceptives provide between four and fourteen dollars in savings for every dollar spent.

Statistics reveal that irreversible sterilization is covered at a higher rate than oral contraceptives, as 86% of large group plans, PPOs and HMOs cover tubal ligation. Women may undergo permanent sterilization for purely economic reasons, even though they would prefer to use contraceptives. Abortion is covered by 66% of indemnity plans, 67% of PPOs and 70% of HMOs. An additional 20% of plans provide restricted coverage, i.e., when an abortion is medically necessary.

Medicaid currently provides funding for contraceptive services. According to the Alan Guttmacher Institute, every tax dollar spent for contraceptive services saves an average of $3 in Medicaid costs for pregnancy-related health care and for medical care of newborns alone. Without publicly funded services, there would be 40% more abortions annually in the United States, and an additional 386,000 teenagers would become pregnant each year.

Opponents of contraceptive coverage include some religious groups. Such groups are concerned with the moral implications and conscience conflicts which may result from such legislation. Religious opponents argue that employers should not be forced to offer and pay for coverage of birth control when it violates their religious teachings and deeply held moral beliefs.

A 1994 study by the Women's Research and Education Institute found that women of reproductive age pay 68 percent more than men in out-of-pocket expenses for health care, and much of this difference in expenditures is due to contraceptive supplies and services. A monthly supply of birth control pills costs between $20 and $60. However, insurance companies are more likely to cover abortion services than contraceptives. A vast majority of insurance plans cover sterilization and vasectomies.

A National Association of Health Plans study suggests that the cost of extending the prescription contraceptive benefit would be $16 per employee each year. According to the American Journal of Public Health, the managed care cost for one year of contraceptive pills is $422, while the cost of prenatal care and delivery for each unintended pregnancy carried to term is $5,512.

According to a recent study by the Alan Guttmacher Institute, providing coverage for the full range of FDA-approved reversible contraceptive methods would result in a total cost of $21.40 per employee per year. With standard cost-sharing between employers and employees, employers would pay $17.12, which translates into monthly cost of $1.43 per employee. Employers' overall insurance cost would increase by only 0.6%.

Another study cautions that increasing governmentally mandated additional coverage will raise the cost of health insurance enough to discourage individuals, who would otherwise opt to carry health insurance coverage, to elect to drop, fail to renew, or otherwise not to obtain health insurance. Dr. William S. Custer, Ph.D., of the Center for Risk Management and Insurance

Research at the College of Business Administration at Georgia State University, presented his study to the Committee on Health Care Services on January 6, 1999. Dr. Custer asserts that there is a significant relationship between increases in coverage mandates and increases in the number of individuals lacking health insurance.

The state group health insurance program includes the self-insured state employees' PPO plan and fully-insured HMOs. Currently, the HMO benefit provides payment for contraceptive services, including prescription drugs, contraceptive supplies, tubal ligations and vasectomies. Contraceptive supplies include an IUD or diaphragm, their insertion and removal, contraceptive implants, their insertion and removal, and contraceptive injections. The PPO plan currently covers tubal ligations and vasectomies. Oral contraceptives and contraception supplies are excluded. PAP smear services, which are required to obtain oral contraceptives, are also non-covered services under the PPO plan. Prescribed contraceptives in the PPO plan are covered when determined as medically necessary and not for the prevention of pregnancy.

The provisions of chapter 627, F.S., relate to insurance coverage requirements. Part VI of this chapter, consisting of ss. 627.601-627.6499, F.S., relates to health insurance policies. Part VII, consisting of ss. 627.651-627.6699, F.S., relates to group, blanket, and franchise health insurance policies. Section 627.6699, F.S., is the "Employee Health Care Access Act," relating specifically to small employer (50 or fewer employees) group health insurance coverage requirements. In addition, part I of chapter 641, F.S., consisting of ss. 641.17-641.3923, F.S., provides health maintenance organization coverage requirements.

Federal Definition of Church Plan

The term "church plan" is defined in the United States Code under the Employee Retirement Income Security Act of 1974 (ERISA). Under ERISA, "church plan" is defined as a plan established and maintained by a church or by a convention or association of churches which is exempt from tax under section 501 of title 26, the Internal Revenue Code. [29 U.S.C. §1002 (1998)] Section 501 of the Internal Revenue Code includes in its list of exempt organizations "corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes." Section 501 also exempts "religious and apostolic organizations" if such associations or corporations have a common treasury or community treasury. [26 U.S.C. § 501 (1999)] Both ERISA and the Internal Revenue Code include several conditions and exceptions to what is considered a "church plan" or an organization operated for religious purposes.

III. Effect of Proposed Changes:

Section 1. Creates the "Equity in Prescription Insurance and Contraceptive Coverage Act of 1999."

Section 2. Provides Legislative findings and intent, including findings that:

- Each year, more than half of all pregnancies in Florida are unintended.
- Contraceptive services are part of basic health care, allowing families to both adequately space desired pregnancies and avoid unintended pregnancies.

- Contraceptives are highly cost effective, yielding from $4 - $14 in savings for every dollar expended.
- By reducing rates of unintended pregnancy, contraceptives help reduce the need for abortions.
- Unintended pregnancies lead to higher rates of infant mortality, low birth weight, and maternal morbidity and threaten the economic viability of families.
- Most women in Florida of childbearing age rely on private employment-related insurance to cover their medical expenses.
- Most private insurers cover prescription drugs, but many exclude coverage for prescription contraceptives.
- The lack of contraceptive coverage in health insurance policies places many effective forms of contraceptives beyond the financial reach of many women, leading to unintended pregnancies.
- The bill constitutes an important state interest.

Section 3. This section provides an exemption from the bill's coverage requirements for individual or group health care service plan contracts purchased by an employer that is a religious health plan sponsor. It authorizes a religious health plan sponsor, church, religious school, religious association, or other religious organization not organized for private profit, to offer a plan that does not provide benefits for prescription oral contraceptives that are contrary to the religious tenets of the religion or the religious corporation, provided the health plan sponsor meets the definition of "church plan" under ERISA, notwithstanding other provisions of law to the contrary. There is an exclusion to the religious exemption; coverage of prescription oral contraceptives may not be denied if necessary to preserve the life or health of the patient. The bill does not require coverage for chemically induced abortions.

Section 4. Creates s. 627.64061, F.S., relating to coverage for prescription contraceptives, to provide that any individual health insurance policy that provides coverage for outpatient prescription drugs must cover prescription oral contraceptives to the same extent and subject to the same contract terms, including copayments and deductible, as any other prescription drug.

Section 5. Amends 627.6515, F.S., relating to out-of-state group health insurance policies, to specify that such group insurance contracts that provide coverage for outpatient prescription drugs must cover prescription oral contraceptives as specified in s. 627.65741, F.S., as created by section 6 of this bill.

Section 6. Creates s. 627.65741, F.S. relating to coverage for prescription contraceptives. The bill provides that any group, franchise, accident, or health insurance policy that provides coverage for outpatient prescription drugs shall cover prescription oral contraceptives to the same extent and subject to the same contract terms, including copayments and deductibles, as any other prescription drug.

Section 7. Amends s. 627.6699, F.S., relating to small employer group health insurance coverage requirements, to specify that such group insurance contracts that provide coverage for outpatient prescription drugs shall cover prescription oral contraceptives as specified in s. 627.65741, F.S., as created by section 6 of the bill.

Section 8. Amends s. 641.31, F.S., relating to health maintenance contracts (HMOs), providing that HMOs that provide coverage for outpatient prescription drugs shall cover prescription oral contraceptives to the same extent and subject to the same contract terms, including copayments and deductibles, as any other drug.

Section 9. Provides an effective date of October 1, 1999.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

This bill may require counties and municipalities to spend funds or to take actions requiring the expenditure of funds related to the provision of employee health benefits. This expenditure would apply to all persons similarly situated. To the extent bill indicates that the Legislature determines that the bill constitutes an important state interest, an exemption would be provided.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

Denial of comprehensive prescription contraceptive coverage may constitute sex-based discrimination prohibited by Title VII. Employers may be in violation of Title VII by failing to provide health benefits including contraceptive coverage.

Title VII makes it unlawful for an employer "to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin." 42 U.S.C. §2000e-2(a)(1). This provision applies to the benefits an employer provides its employees, including health insurance coverage, because "[h]ealth insurance and other fringe benefits are 'compensation, terms, conditions, or privileges of employment.'" Newport News Shipbuilding & Dry Dock Co. v. E.E.O.C., 462 U.S. 667, 682 (1983).

The test of whether a plan discriminates on the basis of gender is whether it treats an employee "in a manner which but for that person's sex would be different." Newport News, 462 U.S. at 683 (holding that a pregnancy limitation in employer's health insurance plan discriminates against male employees by providing only limited coverage for their spouses while providing female employees with full coverage).

In addition to prohibiting per se gender-based discrimination, Title VII prohibits employment practices that have a disparate impact on one gender. To establish a case of disparate impact,

a plaintiff must show that the challenged employment practices "in fact fall more harshly on one group than another without justification." Krauel v. Iowa Methodist Medical Center, 95 F.3d 674, 681 (8th Cir. 1996). Because only women are deprived of prescription contraceptive coverage, proponents of the bill argue that these policies facially discriminate against women.

Proponents suggest that health care plans that deny coverage for oral contraceptives for female employees, while providing coverage for all other pharmaceuticals, essentially provide male employees with a full range of prescription medications and devices while female employees' coverage is limited, and that this constitutes sex based discrimination. This issue has not been litigated in the Florida courts.

Employer-sponsored plans which deny coverage for female employees while providing male employees with comprehensive prescription coverage may also be found to violate the Pregnancy Discrimination Act. This act was enacted to clarify that the definition of sex discrimination under Title VII includes discrimination based on "pregnancy, childbirth, or related medical conditions." 42 U.S.C. §20003-(k). "A woman who is obliged to apply her own income to doctor and hospital bills although male employees are not is obviously earning less for the same work." U.S. Congressional Report of Senate Committee on Human Resources, 95-331 at 5. No court has specifically addressed the issue of whether the Pregnancy Discrimination Act expressly encompasses contraception.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

There will likely be an initial increase in insurance contract costs due to increased contraceptive costs. These may be reduced over time as a result of reductions in costs for pregnancy related coverage. Insurance premiums will likely increase to cover the cost of these enhanced benefits; however, women who have health insurance may be provided expanded coverage for oral contraceptives.

According to a recent study by the Alan Guttmacher Institute, employers' overall insurance cost would increase by only 0.6%. The American Journal of Public Health estimates the managed care cost for one year of contraceptive pills is $422, while the cost of prenatal care and delivery for each unintended pregnancy carried to term is $5,512.

Contraceptive benefits for the state employees' PPO plan would need to be amended to comply with the proposed bill. Specifically, prescription and medical benefits for oral contraceptives would be added to the benefit design. The Division of State Group Insurance would have to issue special member notification to inform PPO plan participants of the proposed benefit changes prior to the enactment of the bill.

Opponents of the bill are concerned that the mandated benefits adversely affect small private employers who purchase fully insured health insurance products for their employees. ERISA exempts self-funded employer-sponsored health plans from state mandated benefits. Many large employers sponsor self-funded health insurance benefits, and they are exempt from state mandated benefits. Most small employers purchase fully insured products, and they must comply with mandated benefits. There is concern that this mandate will force many small employers to forego offering other benefits more attractive to their employees in order to comply with mandates to provide selected benefits. Requirements for disease or condition specific benefits have the potential of increasing the uninsured and underinsured population, particularly among people who rely on small employer insurance.

Opponents assert that small companies will be most affected and cannot afford the increased premiums, which are passed on to their employees, forcing them to leave their plans, thus leaving more people uninsured.

Some plans have refused to provide coverage because contraception medications are preventive in nature. Proponents of the bill suggest that many covered medications, such as for high blood pressure, diabetes, high cholesterol, asthma or allergies, are preventive in nature and are fully covered under an employer's pharmaceutical plan.

The decision of which contraceptive method to use is often a personal preference, but it also may be dictated by medical reasons. Providing coverage for only oral contraceptives may create inequity among plan participants who need assistance in preventing unintended pregnancy.

Individual or group health care service plan contracts purchased by an employer who is a religious health plan sponsor, not organized for private profit, will not be required to provide coverage for oral contraceptives, if the provision of oral contraceptives coverage is inconsistent with the religious beliefs of the organization.

C. Government Sector Impact:

Medicaid will not experience a fiscal impact, as oral contraceptives are currently covered by Medicaid. There will be a fiscal impact to the Division of State Group Insurance, as additional notification of benefit changes would be needed to all state group health insurance enrollees. The notification would cost the Division $28,220. This estimate is based on current PPO plan enrollment of 94,061, and a production and bulk rate mailing cost of $.30 per piece of mail. If the new benefits were to become effective on January 1, 2000, notification could occur during the regular open enrollment period and no additional expense for notification would be incurred.

The bill would have no fiscal impact on expenditures for state employee HMOs, as current benefits provide coverage for contraceptive services including, prescription drugs, contraceptive supplies, tubal ligations and vasectomies. However, there would be a fiscal impact on the state employees PPO plan.

The Division has estimated costs to its PPO plan resulting from the bill at $2.3 to $3.8 million for fiscal year 1999-2000. This wide range is due to two different studies used. Milliman & Robertson (M & R), an actuary consulting firm contracted by the Division, estimated that the annualized fiscal impact of the bill would be approximately $3.8 million. M&R's estimate was based on its assumption that utilization changes as a result of the bill would follow those M & R has developed, which incorporate M & R's health cost guidelines and the firm's knowledge of prescription drug services. The projected increase in fiscal year 1999-2000 represents approximately a 4 percent increase in prescription drug costs for the period. No data was provided on how this cost increase may be reduced or offset in the future, by a decrease in pregnancy, maternity and pediatric services needed.

The second estimate of $2.3 million was based on a national study, using the projected number of users in the PPO plan, and the expected average costs per user. This amount reflects only oral contraceptive prescription drugs. The costs on other medical services, such as the PAP smear tests required to obtain oral contraceptives, are expected to increase the overall plan costs. Actual expenditures for covered prescription contraceptives (those due to medical necessity) are not subtracted from the total estimated expenditures. Cost reductions due to discounts, copayments, coinsurance and deductibles have not been included.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Representatives of the Division of State Group Insurance have expressed concern with the October 1, 1999, implementation date. This date would not allow for notification of plan participants of relevant changes during the annual open enrollment period, which generally occurs from mid-October to mid-November. Any benefit changes occurring other than at the beginning of the plan year (January 1) require the Division to issue special notification to plan participants. The Division would incur additional administrative costs that are not budgeted.

Section 614.215, F.S., requires that any proposal for legislation which mandates a health benefit coverage must be submitted with a report to the Agency for Health Care Administration and the legislative committee having jurisdiction which assesses the social and financial impacts of the proposed coverage. No report has been provided to the Banking and Insurance Committee to date.

VIII. Amendments:

None.