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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH PROMOTION
ANALYSIS

BILL #: HB 381

RELATING TO: Health Insurance/Oral Contraceptives

SPONSOR(S): Representative(s) Rich and others

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH PROMOTION YEAS 9 NAYS 3
(2) INSURANCE
(3) HEALTH & HUMAN SERVICES APPROPRIATIONS
(4) COUNCIL FOR HEALTHY COMMUNITIES
(5)

I. SUMMARY:

HB 381 creates the "Equity in Prescription Insurance and Contraceptive Coverage Act." The bill provides Legislative findings and intent. The bill requires that a health maintenance contract, a health insurance policy, and any group, franchise, accident, or health insurance policy, and any group, franchise, accident, or health insurance policy that provides coverage for outpatient prescription drugs must cover prescription oral contraceptives. The bill provides an exclusion from the mandate for a religious health plan sponsor.

The bill's effective date is October 1, 2001.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No [x]	N/A []
2.	Lower Taxes	Yes []	No [x]	N/A []
3.	Individual Freedom	Yes [x]	No []	N/A []
4.	Personal Responsibility	Yes [x]	No []	N/A []
5.	Family Empowerment	Yes []	No []	N/A [x]

Less Government: This bill imposes a mandate upon certain health coverage plans and policies and will require the Department of Insurance to be responsible for reviewing additional components of such coverage.

Lower Taxes: This bill may result in increased cost for the provision of heath care coverage for eligible employees by local government employers.

B. PRESENT SITUATION:

General Background – Oral Contraceptives

U.S. Food and Drug Administration Approved Oral Contraceptives

According to the American College of Obstetricians and Gynecologists, 90 percent of health plans cover prescription drugs and devices, but only 49 percent 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. Currently, there are three types of FDA-approved oral contraceptives: the combined pill; the Progestin-only minipill; and emergency contraceptives. Contraceptives are often covered when used for medical treatment purposes other than for birth control.

How the Combination Pill Works

The combination pill has three functions. One is to thicken the mucus plug at the opening of the cervix. This can act as a barrier mechanism to prevent sperm entrance. The main function of the pill is to prevent ovulation. If there is no egg, there can be no fertilization. A third function is to harden the lining of the womb. If fertilization does occur, this can and, at times, does prevent implantation of the fertilized egg within one week of conception.

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, therefore, 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.

To date, thirteen states have passed legislation mandating insurance coverage of contraceptives where a policy covers prescription drugs or devices: California, Connecticut, Delaware, Georgia, Hawaii, Iowa, Maine, Maryland, Nevada, New Hampshire, North Carolina, Rhode Island, and Vermont. 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.

Costs of Contraceptives

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.

Equal Employment Opportunity Commission

The Commission

The Equal Employment Opportunity Commission (EEOC) is a federal adminstrative agency that carries out its work at headquarters and in 50 field offices throughout the United States. Individuals who believe they have been discriminated against in employment begin the EEOC review processes by filing administrative charges. Individual commissioners may also initiate charges that the law has been violated. Through the investigation of charges, if the EEOC determines there is "reasonable cause" to believe that discrimination has occurred, it must then seek to conciliate the charge to reach a voluntary resolution between the charging party and the respondent. If these negotiations are not successful, the EEOC may bring suit in federal court. Whenever the EEOC concludes its processing of a case, or earlier upon the request of a charging party, it issues a "notice of right to sue" which enables the charging party to bring an individual action in court.

The Commission also: issues regulatory and other forms of guidance interpreting the laws it enforces, is responsible for the federal sector employment discrimination program, provides funding and support to state and local fair employment practices agencies (FEPAs), and conducts broad-based outreach and technical assistance programs.

EEOC Decision Relating to Oral Contraceptives Coverage

On December 13, 2000, the EEOC issued a Commission Decision (Decision) regarding prescriptive contraceptives. The Commission found merit in two of the charges of discrimination alleging violations of **Title VII of the Civil Rights Act of 1964 (Title VII)**, as amended by the **Pregnancy Discrimination Act (PDA) of 1978**. The Decision addressed two of the charges of discrimination based on the Respondents'/Employers' failure to provide health insurance coverage for prescription contraceptives while covering a number of other preventive drugs, devices, and services.

According to the Decision, the exclusion of coverage for prescription contraceptives constituted discrimination on the basis of sex and pregnancy. **Title VII prohibits discrimination in employment on the basis of race, color, religion, sex, or national origin (Section 703).** This includes the prohibition of discrimination in hiring, discharge, employment opportunities, training

programs, etc. **The PDA requires equal treatment of women "affected by pregnancy, childbirth, or related medical conditions" in all aspects of employment, including the receipt of fringe benefits.** In 1991, the U.S. Supreme Court in *Int'l Union, UAW v. Johnson Controls, Inc.,* 499 U.S. 187 (1991), held that the PDA protects women from discrimination because they have the ability to become pregnant, and not just because they are already pregnant.

According to the Decision, because the **PDA prohibits discrimination against a woman based on her ability to become pregnant, it also covers a health plan's exclusion of prescription contraceptives, since contraceptives are a means by which a woman may control precisely the ability to become pregnant. While the PDA does not require all employers to provide contraceptives to their employees through their health plans, it does require the employer to provide the same insurance coverage for prescription contraceptives that is provided for other drugs, devices, or services that are used to prevent the occurrence of medical conditions other than pregnancy.**

In the specific case in hand, the Commission considered the particular coverage provided by the Respondents. That plan covered, among other things: vaccinations; prescription drugs to prevent the development of medical conditions, such as those to lower or maintain blood pressure or cholesterol levels; anorectics (weight loss drugs) for those 18 years of age and under; preventive care for children and adults; and preventive dental care. Because each of these drugs and services were used to prevent the occurrence of a medical condition, the Commission determined that the Respondents should cover prescription contraceptives in the same way.

The Decision is a formal Commission determination as to whether there is reasonable cause to believe that unlawful discrimination has occurred with respect to a specific charge or charges. The Decision is not a federal mandate for contraceptive coverage and is specifically limited to the facts as presented to the EEOC in these two complaints. The Decision is not binding on any court, however courts may give the decision due deference.

Health Insurance Mandates

State laws frequently require private health insurance policies and health maintenance organization (HMOs) contracts to include specific coverages for particular treatments, conditions, persons, or providers. These are commonly referred to as "mandated [health] benefits." These mandated benefits affect plans covering an estimated 33 percent of all Floridians and 40 percent of insured Floridians. The nearly one-half of all Floridians who are uninsured or covered under Medicare or Medicaid are not affected. Self-funded plans provided by employers are similarly unaffected because the federal Employee Retirement Income Security Act of 1974 (ERISA) generally preempts state regulation of these plans.

On January 28, 2000, the House Committee on Insurance published its interim project entitled "Managing Mandated Health Benefits: Policy Options for Consideration." The report recognized that while most mandates provide social and health benefits to consumers, "most mandated benefits contribute to the cost of health insurance premiums." Key findings of the report included the following:

- Florida has more mandated benefits than nearly every other state;
- An estimated 33 percent of all Floridians are covered under health plans subject to mandated benefits;
- It is not always apparent in statute which health plans are subject to which state-mandated health benefits;
- The costs of mandated benefits in Florida have not been calculated; and

- The statutorily-prescribed provisions for managing mandated benefits legislation have not been followed.

By most measures, Florida has more mandated benefits than nearly every other state. In preparing this report, the House Insurance Committee staff identified 51 mandated health benefits applicable to either private insurer or HMO plans. In a separate count, Blue Cross/Blue Shield Association placed the number of mandates in Florida Statutes at 44—the second highest in the nation, compared to an average of 25 among all states. [Source: Blue Cross/Blue Shield Association, State Legislative Health Care and Insurance Issues.]

The Employee Retirement Income Security Act of 1974

The provisions of Title I of the Employee Retirement Income Security Act (ERISA) cover most private sector employee benefit plans. Employee benefit plans are voluntarily established and maintained by an employer, an employee organization, or jointly by one or more such employers and an employee organization. "Pension plans," a type of employee benefit plan, are established and maintained to provide retirement income or to defer income until termination of covered employment or beyond. Other employee benefit plans are called "welfare plans" and are established and maintained to provide health benefits, disability benefits, death benefits, prepaid legal services, vacation benefits, day care centers, scholarship funds, apprenticeship and training benefits, or other similar benefits.

In general, ERISA does not cover plans established or maintained by governmental entities or churches for their employees, or plans which are maintained solely to comply with applicable workers' compensation, unemployment, or disability laws. ERISA also does not cover plans maintained outside the United States primarily for the benefit of nonresident aliens or unfunded excess benefit plans.

ERISA Preemption

ERISA preempts any state law that relates to an employee pension or welfare benefit plan. State laws include "all laws, decisions, rules, regulations, or other State action having the effect of law" (29 USC Sec.). 1144. ERISA's preemption clause has been broadly construed by the U.S. Supreme Court, which has found that a state law is preempted if it has a connection with or reference to an employee benefit plan. ERISA preemption applies only to benefits provided through an ERISA-covered employee benefits plan. Because an individual contract of employment may not be covered by ERISA, breach of such a contract may be subject to state law claims.

Church Plan

ERISA also exempts church plans, apparently out of concern for separation of church and state. The exception precludes First Amendment challenges based on entangling government regulation. ERISA accommodates the complex institutional structure of some churches by including as a "church" any related tax-exempt organization (trust or corporation).

A church plan means a plan established and maintained "for its employees (or their beneficiaries) by a church or by a convention or association of churches." A church plan does not include all plans maintained by a church. The statute specifically under ERISA excludes plans established and maintained primarily for the benefit of those "who are employed in connection with one or more unrelated trades or businesses." As amended in 1980, ERISA exempts plans covering religious personnel or church employees and/or employees of religiously-affiliated charitable organizations such as hospitals, schools, and group homes.

Despite this exception to the definition of a church plan, a plan established by a corporation associated with a church can still qualify under ERISA as a church plan. The statute defines church plans to include plans "maintained by an organization, whether a civil law corporation or otherwise…if such organization is controlled by or associated with a church or a convention or association of churches." An organization is controlled by a church when, for example, a religious institution appoints a majority of the organization's officers or directors. To be "associated with a church," the corporation must share "common religious bonds and convictions with that church or convention or association of churches."

C. EFFECT OF PROPOSED CHANGES:

HB 381 creates the “Equity in Prescription Insurance and Contraceptive Coverage Act.”

The bill includes a series of “Whereas” clauses to provide background information relating to two recent U.S. Equal Employment Opportunity Commission administrative decisions relating to the provision of oral contraceptive prescriptive coverage and the need of this bill.

The bill provides legislative findings and intent including the determination that the bill constitutes an important state interest. The bill provides an exclusion for plans provided by religious health plan sponsors. The bill requires certain health insurance policies and health maintenance contracts to provide coverage for prescription oral contraceptives. The bill’s provisions also apply to group coverage to out-of-state groups and to small employer carriers issuing health benefit plans.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Provides that this act may be cited as the “Equity in Prescription Insurance and Contraceptive Coverage Act.”

Section 2. Provides Legislative findings and intent providing background relating to unintended pregnancies, the need for oral contraceptive prescriptive coverage, and the cost effectiveness of such coverage, and providing that the enactment of this bill constitutes an important state interest.

Section 3. Provides an optional exclusion for plans and policy holders of plans provided by religious health plan sponsors.

Subsection (1) provides a general rule that regardless of any other provision of s. 627.64061, F.S., as contained in this bill relating to coverage for prescription oral contraceptives under individual health insurance policies, or s. 627.65741, F.S., as contained in this bill relating to coverage for prescription oral contraceptives under group health insurance policies, a religious health plan sponsor may provide a health plan that does not provide benefits for prescription oral contraceptives that are contrary to the religious tenets of the religion or religious corporation, association, or society as defined in subsection (3). In addition, the requirements of s. 627.64061 and s. 627.65741, F.S., do not apply to an individual health care service plan contract or a group health care service plan contract purchased by an employer that is a religious health plan sponsor, including, but not limited to, any church, religious school, religious association, or other religious organization that is not organized for private profit, if the provision of prescription oral contraceptives is inconsistent with the religious beliefs of the organization.

Subsection (2) prohibits the exclusion of prescription oral contraceptives coverage necessary to preserve the life or health of the patient.

Subsection (3) defines "religious health plan sponsor" as a health plan sponsor that meets the definition of "church plan" under s. (33) of the federal Employee Retirement Income Security Act (ERISA) of 1974.

Subsection (4) provides that nothing in this act shall be construed to require coverage for chemically induced abortions.

Section 4. Creates s. 627.64061, F.S., relating to coverage for prescription oral contraceptives. Requires that individual health insurance policies governed by part IV of chapter 627, F.S., that provide coverage for outpatient prescription drugs must cover prescription oral contraceptives approved by the federal Food and Drug Administration and prescribed by a practitioner authorized by state licensure to prescribe such medication. Requires that such coverage must be provided to the same extent and subject to the same contract terms, including copayments and deductibles, as any other prescription drug.

Section 5. Amends s. 627.6515(2)(c), F.S., relating to out-of-state group health insurance, requiring they provide benefits as specified in s. 627.65741, F.S., relating to coverage for prescription oral contraceptives.

Section 6. Creates s. 627.65741, F.S., relating to coverage for prescription oral contraceptives. Requires any group, franchise, accident, or health insurance policy that provides coverage for outpatient prescription drugs must cover prescription oral contraceptives approved by the federal Food and Drug Administration and prescribed by a practitioner authorized by state licensure to prescribe such medication. Requires that such coverage must be provided 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(12)(b), F.S., relating to the Employee Health Care Access Act, to add statutory reference to s. 627.65741, F.S., relating to coverage for prescription oral contraceptives.

Section 8. Amends s. 641.31, F.S., relating to health maintenance contracts, to add subsection (40), requiring that such contracts that provide coverage for outpatient prescription drugs must cover prescription oral contraceptives approved by the federal Food and Drug Administration and prescribed by a practitioner authorized by state licensure to prescribe such medication when such practioners is under the organization's direct employ, under contract, or other arrangement with the organization to provide health care services to subscribers. Requires that such coverage must be provided to the same extent and subject to the same contract terms, including copayments, as any other prescription medication.

Section 9. Provides for an effective date is October 1, 2001.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

2. Expenditures:

This bill would not affect Medicaid, as oral contraceptives are currently covered by Medicaid.

This bill will have a fiscal impact to the Division of State Group Insurance, as an additional notification of benefit changes would need to be sent to all state group health insurance enrollees. The notification would cost the division approximately $20,957. This estimate is based on current preferred provider organization (PPO) plan enrollment of approximately 96,000, 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, 2002, notification could occur during the regular open enrollment period and no additional expense for notification would be incurred.

The division has estimated costs to its PPO plan to add oral contraceptive coverage to be $2.106 million for fiscal year 2002-2003, and the annualized costs to be $2.106 million. This estimate was provided to the division by Caremark, which provides the PPO plan prescription drug program. However, the estimate does not include the related services or routine gynecological exams necessary in order to obtain a prescription for the oral contraceptives. 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. 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.

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.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

This bill may require local governments to incur expenses to pay additional employee health insurance costs. The bill falls within the purview of Article VII, Section 18 of the Florida Constitution. [See: APPLICABILITY OF THE MANDATES PROVISION below.]

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

There will likely be an initial insurance contract cost 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.

D. FISCAL COMMENTS:

N/A

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

Since the bill may require local governments to incur expenses to pay additional employee health insurance costs, the bill falls with the purview of Article VII, Section 18 of the Florida Constitution, which provides that cities and counties are not bound by general laws requiring them to spend

funds or to take action which requires the expenditure of funds unless certain specified exemptions or exceptions are met. The law is binding on counties and municipalities if the Legislature determines that the law fulfills an important state interest. The bill requires similarly situated persons (private employee health care coverage) to comply with the provisions of the bill and includes as part of Legislative findings and intent a determination that the bill constitutes an important state interest.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

N/A

C. OTHER COMMENTS:

Representatives of the Division of State Group Insurance have expressed concern with the October 1, 2001, 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-September to mid-October. 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 624.215, 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. Such a report has been provided to the Committee on Health Promotion for this proposal.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On March 27, 2001, the Committee on Health Promotion adopted the following “strike-everything” amendment:

Section 1. Creates s. 627.6491, F.S., relating to compliance with decisions of the United States Equal Employment Opportunity Commission (EEOC), to provide that benefits, exclusions, and limitations of individual health insurance policies must comply with and be consistent with decisions of the EEOC rendered prior to January 1, 2001, which held that exclusion or limitation of a specific benefit related to contraceptive coverage when other preventative benefits are covered violates Title VII of the Civil Rights Act of 1964, as amended by the Pregnancy Discrimination Act (PDA) of 1978. The Department of Insurance would determine compliance when approving forms.

Section 2. Creates s. 627.54741, F.S., requiring the same provisions as specified under Section 1 (above) to apply to benefits, exclusions, and limitations offered by group carriers.

Section 3. Amends. 627.6699, F.S., relating to the Employee Health Care Access Act, requiring the same provisions specified Section 1 (above) to apply to benefits, exclusions, and limitations offered to small employers.

Section 4. Amends s. 641.31, F.S., relating to health maintenance contracts, requiring that the same provisions specified under Section 1 (above) to apply to the benefits, exclusions, and limitations offered in health maintenance contacts.

Section 5. Provides an effective date of July 1, 2001, and applicable to policies and contracts issued or renewed on after that date.

VII. SIGNATURES:

COMMITTEE ON HEALTH PROMOTION:

Prepared by:	Staff Director:
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