SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: SB 920

SPONSOR: Senator Wasserman-Schultz

SUBJECT: Health Insurance

DATE: February 18, 2002 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Emrich	Deffenbaugh	BI	Favorable
2.			HC	
3.			AGG	
4.			AP	
5.				
6.				

I. Summary:

Senate Bill 920 would effectively prohibit health insurance policies and health maintenance organization (HMO) contracts from excluding coverage for prescription contraceptive drugs and devices. Specifically, the bill requires that individual and group health insurance policies (including the standard, basic, and limited health benefit policies that must be offered to small employers) and HMO contracts may not exclude coverage for a particular benefit if a determination has been made by United States Equal Employment Opportunity Commission (EEOC) that the exclusion of that benefit under any employer's health benefit plan 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 such compliance in approving policy forms, based on the decisions rendered by the EEOC rendered *prior* to January 1, 2001.

The EEOC benefit determination referenced above was issued on December 12, 2000, and concluded that excluding prescription contraceptive drugs and devices from employee health insurance plans constituted sex and pregnancy discrimination. Women affected by pregnancy, childbirth, or related medical conditions must be treated equally in all aspects of employment, including the receipt of fringe benefits. Employers are barred from singling out pregnancy or related medical conditions in their benefit plans.

While the decision applies only to the two women whose complaints the EEOC considered, it provides guidance to employers on the commission's views on the broad reach of Title VII and the Pregnancy Discrimination Act. The EEOC decision is not binding on the courts, but such courts may give the decision due deference.

This legislation may result in increased costs for private employer health plans as well as state and local government providers of employee health benefits. According to the Florida 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 preferred provider organization (PPO) will experience increased annual costs of $1.6 million. Medicaid already provides coverage for oral contraceptives, so no increased cost will be incurred. (See Economic Impact and Fiscal Note Section, below.)

This bill amends the following sections of the Florida Statutes: 627.6699 and 641.31.
This bill creates the following sections of the Florida Statutes: 627.64191, and 627.65741.

II. Present Situation:

Contraceptive Coverage for Women

While most employment-related insurance policies in the United States cover prescription drugs, many plans exclude coverage for 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. (See Economic Impact and Fiscal Note, below.)

To date, nineteen states have passed legislation mandating insurance coverage of contraception where a policy covers prescription drugs or devises: California, Connecticut, Delaware, Georgia, Hawaii, Iowa, Maine, Maryland, Missouri, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Rhode Island, Texas, Vermont, Virginia, and West Virginia.[1] Most of these states require health insurance policies that cover prescription drugs to also cover prescription contraceptives while other states prohibit such plans from excluding contraceptive services or supplies. Also, some states include an exemption for employers who object to such coverage for religious reasons.[2]

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.

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. 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

[1] National Conference of State Legislatures, January 2002 Report, *Women's Health: Health Insurance Coverage for Contraceptives*.
[2] Eleven states have such a provision.

painful or heavy menstrual periods, symptoms of menopause, and endometriosis, a painful disease in which the uterine lining grows outside the uterus.

Sixty three million U.S. women are in their childbearing years (15-44) and over half of these women are in need of contraceptive services and supplies.[3] The majority of Americans in a recent Kaiser survey support proposals to add contraception as a mandatory component of prescription drug coverage even after being told that their costs for health insurance would rise as a result.[4] Seventy-five percent of the participants supported contraceptive coverage when confronted with a $1-$5 monthly increase and 60 percent with a $15-$20 monthly increase. This survey also found that the public is more likely to support legislation requiring insurance coverage of contraceptives (75 percent) and Viagra (49 percent).

Close to 50 percent of all pregnancies in the United States are unintended and these pregnancies are associated with increased risk for poor pregnancy outcomes.[5] Also, half of all unintended pregnancies end in abortion. A 1994 Florida study showed that 45.8 percent of pregnancies in Florida were unintended, and 24 percent 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. For example, California research shows that access to contraceptives reduces the probability of having an abortion by 85 percent.

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. For example, according to a recent study by the Alan Guttmacher Institute, employers' overall insurance costs for covering reversible contraceptive methods would increase by 0.6 percent, while the cost of prenatal care and delivery for each unintended pregnancy carried to term is $5,512. Proponents assert that more effective contraceptive use translates 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 percent 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 percent of indemnity plans, 67 percent of PPOs and 70 percent of HMOs. An additional 20 percent 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

[3] Alan Guttmacher Institute report on the Cost of Employer Health Plans of Covering Contraceptives, June 1998. That report found that "contraceptive use is a standard part of Americans' lives…almost everyone of reproductive age has been sexually active, and almost all of those who have been have used contraception during periods when they wanted to avoid having a child," quoting a study by J.D. Forrest, "U.S. Women's Experience with Contraception," *Family Planning Perspectives*, 19(3):133, 1987.

[4] Kaiser Family Foundation, 1996.

[5] National Center for Chronic Disease Prevention and Health Promotion.

Medicaid costs for pregnancy-related health care and for medical care of newborns alone. Without publicly funded services, there would be 40 percent more abortions annually in the United States, and an additional 386,000 teenagers would become pregnant each year.

Proponents further argue that denial of contraceptive prescription coverage constitutes discrimination against women, which is prohibited under the federal Title VII provisions. Echoing this view is the federal Equal Employment Opportunity Commission (EEOC) which found an employer in violation of Title VII by failing to provide contraceptive coverage. In December 2000, the EEOC rendered a decision finding that an employer discriminated against its female employees in violation of Title VII of the Civil Rights Act because the employer *excluded* prescription contraceptives from its health insurance plan. The EEOC found that, by excluding prescription contraceptive drugs and devices from its health plan, the employer violated Title VII, as amended by the Pregnancy Discrimination Act (PDA), on the basis of sex and pregnancy.

In its decision, the EEOC found that the employer did cover treatments and services designed to maintain current health for its male employees, e.g., viagra, where patients complained about "decreased sexual interest or energy," but did not cover contraceptive treatments. The opinion stated that employers "may not discriminate in their health insurance plan by denying benefits for prescription contraceptives when they provide benefits for comparable drugs and devises." While the decision applies only to the women whose complaints the EEOC considered, it provides guidance to employers on the commission's views on the broad reach of the federal Pregnancy Discrimination Act (PDA) which forbids workplace discrimination against women because of pregnancy, childbirth or related conditions. Further, although the EEOC decision is not binding on the courts, such courts may give the decision due deference.

Title VII, as amended by the PDA, makes it unlawful for an employer "to discriminate against any individual with respect to his or her 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). It requires equal treatment of women affected by pregnancy, childbirth, or related medical conditions in all aspects of employment, including the receipt of fringe benefits. Thus, employers are barred from singling out pregnancy or related medical conditions in their benefit plans.

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 percent.

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.

Under Florida's 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. However, 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.

Florida Insurance Mandate Requirements

State laws frequently require private health insurance policies and health maintenance organization contracts to include specific coverages for particular treatments, conditions, persons, or providers. These are referred to as "mandated (health) benefits."

Recognizing that "most mandated benefits contribute to the increasing cost of health insurance premiums," while acknowledging the social and health benefits of many of the mandates, the Legislature in 1987 called for a "systematic review of current and proposed" mandated benefits.

At that point, the Legislature had approved 16 mandated benefits. In the 13 years since, the Legislature has approved an additional 35 mandated benefits. With 51 mandated health benefits, Florida now has one of the nation's most extensive set of coverage requirements. A procedural requirement established for reviewing mandated benefits--that proponents submit an impact analysis for any proposed mandate benefit prior to consideration—is found in s. 624.215, F.S. (Source: House Committee on Insurance, Interim Project, "Managing Mandated Health Benefits: Policy Options for Consideration," January 28, 2000.)

Although there has never been a study on the cumulative cost of mandated benefits in Florida, a 1998 Blue Cross/Blue Shield report studied the cumulative cost of mandated benefits in various states including Maryland (only Maryland had more mandates than Florida — 47 at the time of the study, according to the report). According to the report, Maryland mandates are estimated to add 15.4 percent to the average monthly premium for a group policy. In Maine, 19 of its 31 mandates were found to increase premium costs on groups of 21 or more by just over 7 percent.

III. Effect of Proposed Changes:

Section 1. Creates s. 627.64191, F.S., relating to compliance with decisions of the United States Equal Employment Opportunity Commission, to provide that individual health insurance policies may not exclude coverage for a particular benefit if a determination has been made by the United States Equal Employment Opportunity Commission (EEOC) that the exclusion of the benefit under any employer's health benefit plan violates Title VII of the Civil Rights Act of 1964, as amended by the Pregnancy Discrimination Act (PDA) of 1978. The Department of Insurance must determine such compliance in approving policy forms under ss. 627.410 and 627.411, based on the decisions by the EEOC rendered before January 1, 2001.

The EEOC decision referenced above was issued in December 2000 and found that excluding prescription contraceptive drugs and devices from employee health insurance plans constituted sex and pregnancy discrimination. Women affected by pregnancy, childbirth, or related medical conditions must be treated equally in all aspects of employment, including the receipt of fringe benefits. Employers are barred from singling out pregnancy or related medical conditions in their benefit plans.

While the decision applies only to the two women whose complaints the EEOC considered, it provides guidance to employers on the commission's views on the broad reach of Title VII and the Pregnancy Discrimination Act. The EEOC decision is not binding on the courts, but such courts may give the decision due deference.

Section 2. Creates s. 627.65741, F.S., relating to consistency with decisions of the United States EEOC, to require that the same provisions specified under Section 1 (above) apply to group health insurance policies.

Section 3. Amends s. 627.6699, F.S., applying to standard, basic, and limited health benefit plans, to require that the same provisions specified under Section 1 (above) apply to these benefit plans.

Section 4. Amends s. 641.31, F.S., relating to health maintenance (HMOs) contracts, to require that the same provisions specified under Section 1 (above) apply to health maintenance contracts.

Section 5. Provides that the act will take effect October 1, 2001, and shall apply to policies and contracts issued or renewed on or after that date.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Since the 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, 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. This bill requires that similarly situation persons (private and public employee health care coverage) may not exclude coverage for a particular benefit, i.e., contraceptive coverage, but does not state that the act fulfills an important state interest.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

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 costs for providing for contraceptive coverage. 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 0.6 percent. 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.

Opponents of the bill are concerned that the mandated contraceptive benefits would adversely affect small private employers who purchase fully insured health insurance products for their employees. There is concern that this bill's mandate will force many small employers to forego offering other benefits more attractive to their employees in order to comply with the contraceptive mandate. 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. 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. According to officials with Blue Cross/Blue Shield, the current cost to provide HMO subscribers with prescription drug coverage ranges from $24 to $50 per subscriber per month. To provide for contraceptive drug coverage would increase such costs by 5.5 percent per subscriber. For example, contraceptive drug coverage would add approximately $1.32 per subscriber per month if such subscriber paid $24 for current drug coverage and $2.75 per subscriber per month if such subscriber paid $50.

Proponents counter the above arguments by stating that increased access to contraception will allow insurers and thus employers to avoid the costs of unplanned pregnancies and childbirth. According to one estimate, a sexually active woman who does not use contraception over the course of 5 years will experience 4.25 unintended pregnancies, costing upwards of $14,500 for a private insurer. Overall, employers will expend more money and resources to cover an employee's prenatal care and delivery for each unintended pregnancy which is carried to term.

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.

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.

C. Government Sector Impact:

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 to add oral contraceptive coverage to be $1.6 million for fiscal year 2002-2003, and the annualized costs to be $1.6 million. According to the division's fiscal impact report, "coverage of contraceptives will cost an estimated .7 percent of pharmacy spend, which currently represents $1.2 million, and an estimated .1 percent of medical spend, which currently represents $.4 million. 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.

VI. Technical Deficiencies:

None.

VII. Related Issues:

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. Such a report has been provided to the Senate Banking and Insurance Committee.

VIII. Amendments:

None.