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HOUSE OF REPRESENTATIVES
COMMITTEE ON
GOVERNMENTAL OPERATIONS
ANALYSIS

BILL #: HB 83

RELATING TO: Contraceptive Equity Act

SPONSOR(S): Representative Bloom

COMPANION BILL(S): HB 371(c)

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

(1) GOVERNMENTAL OPERATIONS YEAS 2 NAYS 4
(2) INSURANCE
(3) HEALTH CARE SERVICES
(4) GENERAL GOVERNMENT APPROPRIATIONS
(5)

I. SUMMARY:

This bill creates the "Contraceptive Equity Act". It requires that all individual, small employer, group, managed care, and state employee health insurance policies, and multi-employer welfare arrangements providing coverage for the treatment, including drug treatment, of sexual dysfunction, must also cover any contraceptive method prescribed by a licensed practitioner.

Neither of the created statutory sections defines either the term "contraceptive method", or the term "licensed practitioner".

This bill provides an exemption from the basic provisions in cases where parties to contracts, or prescribers find the provisions contrary to their religious beliefs, or moral convictions.

This bill provides an effective date of October 1, 1999.

There is a fiscal impact on the state and local governments. The Division of State Group Insurance provided a fiscal impact of approximately $2.5 million per annum on the state's Preferred Provider Organization plan. Representatives of Blue Cross, Blue Shield state that they provided the Division of State Group Insurance with this estimate over a year ago. At that time only contraceptive pills were included in the estimate. Blue Cross, Blue Shield's current estimate is about $4.5 million for contraceptive pills, devices, implants, and injections. This amount includes $3 million for contraceptive pills, and about $1.5 million for other forms of contraception.

At the time of this report, the local governments had no documented fiscal impact figures.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Due to the sensitive nature of contraceptive issues, it is difficult to feel confident with offerings from the many organizations and parties who may have agendas related to legislation. There seems to be no dearth of studies and informed opinions. The Florida House of Representatives Committee on Health Care Services has spent many months researching this issue, and have, as expected, compiled a collection of newspaper articles, studies, and informed assertions. These sources address costs, medical benefits and disadvantages, and social benefits and disadvantages tied to various contraceptive-related issues. There have also been "equity" issues raised comparing contraceptive methods to sexual dysfunction issues.

Due to the nature of the subject, the sometimes notable, even seemingly contradictory evidence may be confusing. In order to present a fair overview of positions, such evidence is presented. Most of the studies cited have been researched by the Committee on Health Care Services, and details can be obtained from that committee staff.

While most employment-related insurance policies in the United States cover prescription drugs, a vast majority excludes 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. Insurance companies further argue 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, 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, 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 some contraceptive care.

Legislation requiring contraceptive coverage also 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 they pay for other drugs. The federal law provides exemptions for religiously affiliated plans and doctors with moral objections.

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.

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 argue that providing a policy holder 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.

Opponents of contraceptive coverage also include religious groups. Such groups, particularly Catholic organizations, are concerned with the moral implications and conscience conflicts that 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.

It should be noted that contraceptives are 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.

A 1994 study by the Women's Research and Education Institute in Washington 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 $30. Insurance companies are more likely to cover abortion services than contraceptives. A vast majority of insurance plans cover sterilization and most insurers pay for vasectomies.

A National Association of Health Plans study asserts 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 contraceptives 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 on January 6, 1999. Dr. Custer discusses public policy and the uninsured, He asserts that there is a significant inverse

relationship between coverage mandates and the likelihood that individuals will lack health insurance. That is, increases in coverage mandates resulted in an increase in the number of individuals lacking health insurance.

A recent poll by the Kaiser Family Foundation (KKF) indicated that America's public supports mandating contraceptive insurance coverage. According to the poll, seventy-eight percent of adults support contraceptive coverage, even if coverage would increase their insurance costs by $5 a month. Among privately insured women, support for contraceptive coverage rises to 88 percent.

The KKF poll also indicated that seven out of ten privately insured Americans and eight out of ten insured women believe that coverage should include all FDA-approved contraceptive methods.

In March of 1998, the U.S. Food and Drug Administration gave approval to Viagra, the first pill to treat impotence in men. Viagra costs about $7 a pill. When it was first released, analysts predicted that the pill would become one of the top-selling drugs of all time, with sales reaching $500 million by 2003. Within four months of approval, 3.5 million prescriptions were written and about 30 million tablets were dispensed.

B. EFFECT OF PROPOSED CHANGES:

Health insurance policies and health maintenance contracts that provide coverage for the treatment of sexual dysfunction will be required to provide coverage for any contraceptive method prescribed or provided by a licensed practitioner. An insurer will not be required to provide coverage for contraceptives if the parties to the contract or the prescriber objects on religious or moral grounds.

Proponents state that the term "any contraceptive method" is intended to include only methods such as birth control pills, injections, condoms and devices. Opponents raise questions as to what might be eventually be included in the term "any contraceptive method", as some family planning organizations use the term to include methods of termination of pregnancy.

According to proponents of this bill, the term "licensed practitioner" is intended to refer to licensed physicians. A concern has been raised that this term may be expanded in the future to define other classes of prescribers.

C. APPLICATION OF PRINCIPLES:

1. <u>Less Government:</u>

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

No.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

Yes, certain health insurance policies that provide coverage for drugs prescribed for the treatment of sexual dysfunction must cover any contraceptive method prescribed or provided by a licensed practitioner.

(3) any entitlement to a government service or benefit?

No.

b. If an agency or program is eliminated or reduced:

This bill does not eliminate or reduce an agency or program.

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. <u>Lower Taxes:</u>

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

No.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

No.

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

Eventually. When insurance contracts are entered into or renewed, it is almost certain that additional expenses incurred by the insurance providers will be passed on in part, or in whole, to their clients.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

Certain health insurance policies will cover contraceptive drugs, devices, and all other contraceptive methods, giving women additional choices in birth control alternatives.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

No.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

This bill does not purport to provide services to families or children.

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

No.

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

This bill does not create or change a program providing services to families or children.

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

Creates ss. 627.64061, and 627.65741, F.S. Amends ss. 627.651, 627.6515, 627.6699, and 641.31, F.S.

E. SECTION-BY-SECTION ANALYSIS:

Section 1. Establishes that this act may be cited as the “Contraceptive Equity Act”.

Section 2. Creates s. 627.64061, F.S., relating to coverage for contraceptive methods, providing that any health insurance policy that provides coverage for drugs prescribed for the treatment of sexual dysfunction shall cover any contraceptive method prescribed or provided by a licensed practitioner. No insurer will be required to provide coverage if the parties to the contract or the prescriber objects on religious or moral grounds.

Section 3. Amends s. 627.651, F.S., relating to group contracts and plans of self-insurance, applying certain requirements for multiple-employer welfare arrangements.

Section 4. Amends s. 627.6515, F.S., relating to out-of-state group health insurance policies, to apply.

Section 5. Creates s. 627.65741, F.S., relating to coverage for contraceptives, providing: that any group, franchise accident, or health insurance policy that provides coverage for the treatment of sexual dysfunction shall cover any contraceptive method prescribed or provided by a licensed practitioner; that no insurer will be required to provide coverage if the parties to the contract or the prescriber objects on religious or moral grounds; and specifically providing for application of this legislation to benefits for state employees under s. 110.123, F.S. (This deals with state group health insurance)

Section 6. Amends s. 627.6699, F.S., relating to the Employee Health Care Access Act, to apply certain requirements for group coverage to coverage for small employers.

Section 7. Amends s. 641.31, F.S., relating to health maintenance contracts, to provide that any health maintenance contracts that provide coverage for drugs prescribed for the treatment of sexual dysfunction shall cover any contraceptive method prescribed or provided by a licensed practitioner. No insurer will be required to provide coverage if the parties to the contract or the prescriber objects on religious or moral grounds.

Section 8. Provides an effective date of October 1, 1999.

III. <u>FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT</u>:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. <u>Non-recurring Effects</u>:

None.

2. Recurring Effects:

   The Division of State Group Insurance estimates the fiscal impact on the State Employees' PPO Plan for contraceptive pills and devices prescribed or provided by licensed practitioners to be $2.5 million per year.

   There would be cost reductions due to discounts, co-payments, co-insurance, and deductibles, if applied.

3. Long Run Effects Other Than Normal Growth:

   Unknown. There may be reductions or increases in costs depending on definitions of "licensed providers" and "contraceptive methods". There may be increases or decreases over time based on changes in the cost of insurance contracts due to increased contraception costs, reduced by offsetting reductions in costs such as those for pregnancy coverage.

4. Total Revenues and Expenditures:

   Unknown.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

   None.

2. Recurring Effects:

   Unknown. Local governments had no estimates at the time of the drafting of this analysis, but the League Of Cities anticipated a fiscal impact on city governments.

3. Long Run Effects Other Than Normal Growth:

   See III. A. 3. above.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   Unknown. For a time, there will probably be a negative fiscal impact on the private sector, but costs to private sector firms and individuals could eventually be either higher, or lower, depending on the extent of reduced costs to insurance providers due to offsetting circumstances such as significant reductions in pregnancy related expenses.

2. Direct Private Sector Benefits:

   Unknown.

3. Effects on Competition, Private Enterprise and Employment Markets:

   N/A

D. FISCAL COMMENTS:

None.

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

A. APPLICABILITY OF THE MANDATES PROVISION:

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.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

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

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:

At its meeting on January 21, 1999, the Committee on Governmental Operations reported this bill unfavorably. The vote was 2 yeas, and 4 nays.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

None.

VII. SIGNATURES:

COMMITTEE ON GOVERNMENTAL OPERATIONS:

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