Mandated Benefits Review

Senate Bill 1094
Contraception Drugs and Devices

The Pennsylvania Health Care Cost Containment Council

May 2000

Table of Contents

EXECUTIVE SUMMARY

After reviewing the analysis of Senate Bill 1094–the Prescription Contraception Equity Act–the Pennsylvania Health Care Cost Containment Council does not find sufficient evidence to recommend this bill at this time. Comments and observations made in this review are relevant to House Bill 11 and House Bill 109, legislation also calling for contraception coverage that was brought to the Council's attention by the prime sponsors of these bills, though not formally submitted to PHC4 for review.

There was general consensus in the submissions of both proponents and opponents that implementation of SB 1094 would increase the cost of purchasing health insurance in the Commonwealth, in particular the pharmacy benefit, the cost of which has been increasing at an unprecedented rate. There were, however, substantial differences in projections of the *amount* of the increase. Moreover, while savings are likely from this measure, the *amount* of possible savings relative to the cost of the legislation is unclear, as is the extent to which the savings would be passed on to the purchasers of health care.

Neither proponents nor opponents submitted a sufficient number of *actuarially based* studies which would enable the Council to effectively address the cost effectiveness of this legislation. Though proponents and opponents made claims concerning the costliness of the mandate or the amount of money that could be saved, these claims were not supported by sufficient documentation. In particular, no studies were submitted, nor were we able to locate any, that supported claims of savings from avoiding unwanted pregnancies or reducing abortions as a result of mandating contraceptive coverage for the *population affected by this legislation*. Another prime concern was the fact that no Pennsylvania-specific information was submitted, nor were we able to locate any, concerning the rate of unintended pregnancy or the rate of prescription birth control use among the particular population of women affected by this mandate, i.e. those covered by private health insurance.

Several social issues which the Council found to be outside its purview were emphasized in submissions from both proponents and opponents. An argument central to the proponents' position relates to the "gender equity" issue, which has taken on new impetus since the introduction of the drug Viagra. Another social issue concerns the objections of religious-based organizations to a mandate which conflicts with religious beliefs concerning the use of birth control. Another policy issue which the Council found to be outside the scope of their charge was judging the medical necessity of the proposed benefit. Submissions differed in their interpretation of whether the contraceptive benefit mandated in SB 1094 was "medically necessary." While opponents claim that contraceptives are *not* a medical necessity, proponents contend that contraception is a critical aspect of medical care and preventative medicine.

While the Council acknowledges that these issues are personally compelling for many, it must be noted that the Council's charge is to focus on *health care quality and cost containment.* Though social impact is a consideration, the Council is concerned foremost with quality and cost issues in reviewing insurance mandates. Decisions of equity, religious views, or medical necessity are not within the Council's scope of judgement.

We note the following points:

- There is particular concern that the coverage mandated in Senate Bill 1094 is tied to prescription drug coverage. Private insurance payments for prescription drug coverage are increasing at an unprecedented rate (an average of 15%-20%), comprising the single largest component of health care cost increases. For example, a Pennsylvania HMO recently submitted a filing for prescription drug riders, requesting a rate increase of 28%. The Council suggests that it is an inopportune time to increase the cost of prescription drug coverage. If rising costs force employers to drop prescription drug riders, all employees and their families, not just those members who purchase contraceptives, will lose a valuable

benefit. The potential loss of prescription drug coverage is of serious concern to all Pennsylvania families.

- The Council finds that the information submitted lacks sufficient specificity to make informed projections with regard to the cost effectiveness of this coverage. Proponents and opponents made claims concerning the costliness of the mandate and possible savings due to prevention of unintended pregnancy. A range of cost estimates were presented. The lowest cost figure, a yearly cost of $55.8 million, was derived from a study submitted by proponents. Using cost estimates submitted by opponents resulted in a range of $72 to $145 million, with one opponent submitting a yearly cost of $411 million. While it is likely that there may be savings as a result of increasing access to contraception, conjecture concerning possible savings due to reducing unintended pregnancy, abortion and low birth weight babies was not supported with enough substantive documentation to arrive at a reliable figure. While an average of $61 million was estimated, sufficient information specific to Pennsylvania and the population covered by this legislation was not submitted for this projection to be considered conclusive. Without this information, the figures are difficult to reconcile.

- The Council found that it was not possible to rely on the experience of other states. All states which have enacted mandates for contraceptive coverage have done so within the last two years (nine of the ten within the last year), an amount of time insufficient to fully determine financial or social impact.

- With regard to current coverage of contraceptives, it was estimated that approximately 54% of the 1.6 million Pennsylvania women who are potential candidates for contraception receive coverage for *oral contraceptives* through HMOs or Medicaid. Approximately 32% receive coverage for *all five reversible methods* through HMOs or Medicaid. These percentages are a minimum because they do not include those women receiving contraceptive coverage through PPO, POS or indemnity insurance plans. Uninsured or underinsured women have access to subsidized family planning clinics.

- Finally, the Council's enabling legislation provides for a preliminary review of submitted materials to determine if documentation received is sufficient to proceed with the formal Mandated Benefits Review process outlined in Act 34 of 1993. We conclude that neither supporters nor opponents of the bill provided sufficient information to warrant a full review by a Mandated Benefits Review Panel; nor, given the documentation received, do we believe a panel of experts would come to conclusions different than the ones reached here.

The Council suggests that caution must be used when considering health care mandates. In particular, attention must be given to the cumulative financial effect of enacting mandates, especially in light of the fact that, while mandates increase the cost of health insurance generally, a state mandate will cover, on average, only 42% of the state's population (only 33% of the state's population if the mandate applies to group plans only).

The rise in the number of uninsured Pennsylvanians is of particular concern. The Health Insurance Association of America (HIAA) has reported that the number of uninsured under age 65 in Pennsylvania has jumped 34% since 1991, more than double the national increase of 16%. The role of mandates in this trend is not clear. It can be noted, however, that the number of mandates in Pennsylvania (currently almost 30) has grown in concert with rising costs of health insurance and the growing number of uninsured.

The Council contends that some mandates may be cost effective. For others, however, the balance is not so clear. While the Council is sensitive to social issues surrounding the coverage of contraceptives, insufficient cost related actuarial studies were submitted in order to determine that coverage of contraceptives and contraceptive services would be cost effective.

Review of Senate Bill 1094

The Prescription Contraception Equity Act

Overview of Senate Bill 1094

SB 1094, the proposed Prescription Contraception Equity Act provides that health insurance policies may not exclude or restrict coverage for:

- Any contraceptive drug or device approved by the FDA, if the policy provides coverage for other prescription drugs or devices.

- Outpatient medical or counseling services necessary for the effective use of contraception, if the policy provides coverage for other outpatient medical or counseling services.

Insurers are prohibited from:

- Denying eligibility because of past, present or future use of contraceptive drugs, devices or medical or counseling services.

- Providing monetary payments or rebates to insureds to encourage them to accept less than the coverage required by this legislation.

- Penalizing or limiting the reimbursement of health care professionals because they have or will prescribe contraceptive drugs or devices or provide medical or counseling services.

- Providing monetary or other incentives to a health care professional to withhold from any insured contraceptive drugs or devices or medical or counseling services required by this legislation.

Policies may still impose limitations in relation to coverage for prescription contraceptive drugs, devices or outpatient medical or counseling services, provided that the limitation for this coverage is not greater than or different from limitations imposed under general terms and conditions applicable to all other prescription drugs, devices or outpatient medical or counseling services.

Policies are not required to cover experimental prescription contraceptive drugs or devices or outpatient medical or counseling services, except to the extent the policy already provides coverage for experimental prescription drugs, devices or outpatient medical or counseling services.

The provisions in SB 1094 are identical to those of two other proposals currently under consideration by the General Assembly, House Bill 11 and House Bill 109, both also called the Prescription Contraception Equity Act.

The Mandated Benefits Review Process

The Pennsylvania Health Care Cost Containment Council's enabling legislation, Act 89 of 1986 (as reauthorized by Act 34 of 1993), provides that the Council review existing or proposed mandated health benefits when requested by the Secretary of Health or appropriate committee chairmen of the Pennsylvania Senate or the House of Representatives.

In November 1999, Senator Edwin G. Holl, Chairman of the Senate Banking and Insurance Committee, requested that the Council review the provisions of Senate Bill 1094 (PN 1330–Senator Schwartz).

Notification was published in the *Pennsylvania Bulletin* (November 20, 1999) requesting that interested parties submit documentation and information pertaining to the bill to the Council by January 20, 2000. Letters also were sent to potentially interested individuals and organizations informing them of the pending review and inviting them to submit documentation pursuant to the notice. Following the initial comment period, an opportunity was provided for interested individuals and organizations to examine the responses received and submit additional comments based on that review by March 13, 2000. The Pennsylvania Department of Health and the Insurance Department were notified and received copies of the submissions.

A list of the submissions received and a copy of the bill are attached.

Act 34 provides for a preliminary Council review of submitted materials to determine if documentation submitted is sufficient to proceed with the formal Mandated Benefits Review process outlined in the Act. This report presents the results of the Council's preliminary review.

Analysis Of Documentation Submitted By Opponents And Proponents In Response To The Eight Categories Required By Act 34, Section 9

Act 34 of 1993 provides that the documentation submitted to the Council by supporters and opponents of a proposed mandated benefit should address eight specific areas. In reviewing these eight points, determination is made whether the information received is sufficient to warrant the formal Mandated Benefits Review process outlined in the Act. Following are Council findings pertaining to the documentation received for SB 1094 addressing each of these eight points.

Summary of Proponent Responses

Supporters of SB 1094 contend that the Prescription Contraception Equity Act addresses the issue of fairness in health care for women. Women of reproductive age spend 68% more than men on out-of-pocket health care costs. Contraception services account for a large proportion of this amount. According to the Kaiser Family Foundation, 33% of indemnity plans and 84% of HMOs routinely cover oral contraceptives. However, only 15% of indemnity plans and 39% of HMOs cover *all five* of the most effective reversible methods of contraception, i.e. oral contraceptives ("the pill"), Depo-Provera, Norplant, the IUD, and the diaphragm.[1]

Supporters of SB 1094 maintain that preventing unintended pregnancies is a public health issue. Prevention of unintended pregnancies reduces infant morbidity and mortality because a woman carrying an unintended pregnancy is less likely to seek early prenatal care and reduces abortion.

Proponents cite a published study, *Cost to Employer Health Plans of Covering Contraceptives,* commissioned by The Alan Guttmacher Institute. This study estimates the cost of adding insurance coverage for FDA-approved contraception to be $21.40 per employee per year ($17.12 of *employers'* costs and $4.28 of *employees'* costs).

Supporters of this legislation argue that the cost of the legislation is reasonable in light of the benefits it would convey, especially when compared to the cost of an unintended pregnancy. Estimates of the cost to an insurance company for a pregnancy ranged from $3,000 to $8,600. The Council's data indicates that in Pennsylvania, the average hospital charge for a delivery is approximately $5,500.

Summary of Opponent Responses

Opponents of SB 1094 maintain that this legislation would substantially increase the cost of health care for both employers and for employees. It is noted that since increases in prescription drug premiums are responsible for a large portion of recent overall insurance benefit cost increases, this is an inopportune time to mandate a higher level of drug coverage. Opponents fear that the passage of SB 1094 may encourage some companies to reexamine the feasibility of providing any prescription drug coverage to their employees. Contraceptive coverage is usually available as an option an employer can choose to include in their benefits package. Furthermore, they contend that the underpinning of medial insurance is "medical necessity"; and, in their view, coverage of contraceptives is not "medically necessary."

Some opponents assert that this legislation would mandate Catholic employers to provide coverage for services that are morally objectionable and contrary to Catholic church teaching.

In general, opponents claim that mandates increase premiums, which may result in employers dropping health benefits for their employees, thereby increasing the number of uninsured. Furthermore, opponents maintain that the cost of mandates is often borne by employees in the form of reduced wages, reduced work hours or lost employment.

Specific Responses to the Eight Categories Required by Act 34

(i) The extent to which the proposed benefit and the services it would provide are needed by, available to and utilized by the population of the Commonwealth.

According to the Pennsylvania Department of Health, there were 2.9 million women of reproductive age – between the ages of 15 and 44 – in Pennsylvania in 1997. The Alan Guttmacher Institute estimates that there are 1.6 million women (including 235,800 teenagers) in Pennsylvania who are potential candidates for utilization of contraceptive supplies, i.e. they are of reproductive age and sexually active.[2]

According to The Alan Guttmacher Institute, the average U.S. woman spends about three-quarters of her reproductive life trying to avoid pregnancy. A woman who wants only two children will need to practice contraception for at least 20 years. Nationally, the proportion of women practicing birth control has been on the rise since the early 1980s. By 1995, nearly two-thirds (64%) of U.S. women ages 15-44 were using some form of contraception.[3] Opponents of SB 1094 suggest that these numbers serve to confirm the assertion that contraceptives are in fact already widely available and utilized without a mandate. Tubal sterilization is the most utilized method of contraception (27.7%). The next most popular method is oral contraceptives, which are used by 26.9% of women using contraception. Injectables, implants, diaphragms and IUDs are each used by less than 2% of women.[4] No information was submitted to indicate whether these figures hold true for Pennsylvania women.

The Department of Health reports 181,016 pregnancies in Pennsylvania in 1997 (approximately 71 pregnancies per 1,000 women aged 15-44). Of this number, there were 143,967 live deliveries, 35,478 abortions, and 1,571 fetal deaths. According to the 1996 PRAMS Surveillance Report (Pregnancy Risk Assessment Monitoring System) by the Centers for Disease Control and Prevention (CDC), nearly half of all pregnancies are unintended. Approximately 14% of the unintended pregnancies are "unwanted", while the remaining pregnancies are "mistimed." [5]

The Women's Law Project submission utilizes numbers relating to pregnancies in Pennsylvania which differ from those reported by the Pennsylvania Department of Health. The Pennsylvania Department of Health reports that the pregnancy rate in Pennsylvania for 1997 is 70.9 pregnancies per 1,000 women aged 15-44 (181,016 pregnancies). The Centers for Disease Control's National Center for Health Statistics, whose numbers are the basis for many of the proponents' estimates for possible savings as a result of SB 1094, reports the Pennsylvania pregnancy rate to be 95 pregnancies per 1,000 women aged 15-44. Utilizing this pregnancy rate for Pennsylvania's 2.6 million women aged 15-44 results in an estimate of 247,000 pregnancies. This is quite a discrepancy, one which has substantive effects on cost estimates. The figures are based on different criteria. The Pennsylvania Department of Health pregnancies include live births, induced abortions and fetal deaths (including all miscarriages occurring after sixteen weeks). Fetal deaths (non-induced) occurring before sixteen weeks are not collected by the Department of Health. The CDC includes these numbers as well as an estimate of miscarriages occurring too early to be reported. The CDC also builds in an assumption of under-reporting of both fetal loss and abortions in their estimate.

No Pennsylvania specific numbers were submitted concerning the utilization of contraceptives. In addition, the percentage of those who use contraceptives who are covered by private insurance is unknown.

(ii) *The extent to which insurance coverage for the proposed benefit already exists, or if no such coverage exists, the extent to which this lack of coverage results in inadequate health care or financial hardship for the population of the Commonwealth.*

Both proponents and opponents included in their submissions estimates of the percentage of insurance plans in the United States that cover contraceptives. There was a general consensus in the submissions, though some percentages varied slightly. A fairly representative and comprehensive table of contraceptive coverage in the United States as of 1995 is displayed below.[6] In general, the coverage varies by type of insurance product. HMOs are the most likely to cover contraceptives, while indemnity plans are the least likely to routinely include such coverage. Since specific figures for Pennsylvania were not submitted, determining the extent of coverage in Pennsylvania can only be estimated by looking at national figures.

Methods	Indemnity	PPO	POS	HMO
Pill	33%	41%	60%	84%
Depo-Provera	39%	35%	72%	74%
Norplant	28%	29%	54%	59%
IUD	26%	25%	46%	86%
Diaphragm	21%	23%	46%	81%
All 5 reversible	15%	18%	33%	39%
No reversible	49%	18%	33%	7%
Tubal Ligation	86%	86%	90%	86%
Vasectomy	85%	86%	90%	88%
Abortion	66%	67%	83%	70%

Source: Uneven & Unequal: Insurance Coverage and Reproductive Health Services

Coverage may vary in some geographical areas. The Alan Guttmacher Institute reports lower figures from a 1996 survey of the Washington Business Group on Health in which 53% of its members' HMO plans covered oral contraceptive pill, compared with 28-33% of their PPO/POS and fee-for-service plans.[7] This suggests that coverage in Pennsylvania may vary from the above chart.

Proponents note that a higher percentage of plans cover sterilization than cover non-permanent methods of contraception. Proponents also argue that a large proportion of health plans cover abortion (see chart). The Women's Law Project states that, according to the National Abortion & Reproductive Rights Action League of Pennsylvania (NARAL-PA), 64% of *Pennsylvania* health plans cover abortion.[8] These figures do not clarify whether the coverage referred to is for all elective abortions or for abortions meeting certain criteria. The only information offered regarding this issue was that at least some plans cover abortions only when the pregnancy endangers the health of the mother or when the pregnancy is the result of rape or incest. Further, while 64% of Pennsylvania health plans may *cover* abortions, it is also not clear what *percentage of abortions* performed in Pennsylvania are covered by private insurance.

Opponents emphasize that there is already significant insurance coverage of at least some contraceptive methods, if not all five listed in the legislation. The Managed Care Association notes that almost one-half of Pennsylvania's insured population – an estimated 5.5 million people – has coverage through a managed care plan. If Pennsylvania figures follow national ones as presented in the table above, then this type of coverage is more likely to include contraceptives.

Proponents counter that family planning is *not* enabled by the coverage of one or two methods of contraception. Unintended pregnancy is minimized only when each woman has access to the method best for her. The Women's Law Project states, "It follows that the relevant statistic is not what percentage of insurers cover some method of contraception, …but what percentage cover all prescription methods." [9]

Opponents claim that uninsured or underinsured women have access to subsidized prescription contraceptives through various other avenues. The Managed Care Association contends that, "…there are numerous options available to women of all economic levels who wish to prevent pregnancies."[10] This submission mentions other already existing avenues of coverage for contraceptives: for example, health plans that provide coverage for Medicaid enrollees are also mandated to provide contraception. Currently, according to the Department of Public Welfare, 318,023 women between the ages of 15 and 45 are covered by Medicaid, thus have contraceptive coverage. The Department of Public Welfare reports that family planning services were supplied to a total of 41,189 recipients at a total cost of $5,552,480 for the fiscal year 1998-1999. This translates to an average of $134.80 per recipient. In this time frame, there were 99,849 claims paid for contraceptive prescriptions for 26,227 recipients, at a cost of $3,443,212, an average of $131.28 per recipient. Uninsured or underinsured women have the option to use family planning clinics which provide services to clients regardless of age, income or insurance status. Often a sliding fee scale is used.

Proponents argue that the current level of coverage results in financial hardship for some women. According to the Alan Guttmacher Institute, costs for supplies alone can run $360 per year for oral contraceptives, $180 per year for the injectable Depo-Provera, $450 for the Norplant implant, and $240 for an IUD. The cost of office visits, if not part of a routine yearly check-up, must be added to these amounts.[11] Proponents make the point that prescription contraceptive methods have a lower failure rate than over-the-counter methods. The Women's Law Project cites studies which conclude that there is a link between unintended pregnancy and the use of non-prescription birth control (copies of these studies were not submitted). Planned Parenthood of Western Pennsylvania claims,

> Some [women] may opt for their second or third choice in contraception because it's the most affordable. This could mean a less effective method, or one that might not be best for them for health reasons. ... Or, of course, she may be forced to pay for her first choice entirely out-of-pocket, and often this means inconsistent – thus ineffective – use of contraception.[12]

The Alan Guttmacher Institute's submission states that according to a poll commissioned by the Kaiser Family Foundation, three in four adult women say cost is an important factor when choosing a birth control method. According to The Alan Guttmacher Institute,

> Some methods, like the IUD and the contraceptive implant, Norplant, have up-front costs that can be prohibitive for women without significant discretionary income; at the same time, they are among the most effective of all methods. Similarly, cost concerns may affect how well women are able to use their chosen method. Some women may delay refilling a prescription for oral contraceptives, for example, or put off obtaining a Depo Provera injection because of cash-flow problems. And even a brief gap in method use can have a major impact. Notably, half of the unintended pregnancies in the United States are to women who are "using" contraception – but not always consistently or with maximum effectiveness.[13]

In the absence of Pennsylvania specific numbers, a very general estimate of coverage in Pennsylvania may be attempted. There are a total of 980,988 women between the ages of 20 and 44 currently enrolled in HMO plans in Pennsylvania.[14] Of this number, approximately 201,377 receive HMO coverage through Medicaid.[15] Based on the above chart, it can be estimated that approximately 505,425 women in this age group have contraceptive coverage for

all five reversible methods through their HMOs (201,377 covered by Medicaid HMOs plus 304,048 [39% of the remaining 779,611] covered by private HMOs). Based on the numbers of women covered by Medicaid and private HMOs, a minimum of 32% of the 1.6 million Pennsylvania woman who are potential candidates for contraceptive services have coverage for all five reversible methods.

Of women who use reversible methods of contraception, oral contraceptives are the leading method. Based on the above chart, it can be estimated that approximately 856,250 women in this age group have contraceptive coverage for oral contraceptives through their HMOs (201,377 covered by Medicaid HMOs plus 654,873 [84% of the remaining 779,611] covered by private HMOs). Based on the numbers of women covered by Medicaid and HMOs, a minimum of 54% of the 1.6 million Pennsylvania women who are potential candidates for contraceptive services have contraceptive coverage for oral contraceptives.

Because it is not clear how many of those covered by HMOs are sexually active and want to use contraception, it was not possible to include this consideration in the estimate. *This estimate is a minimum, because it does not include those women receiving contraceptive coverage through PPO, POS or indemnity plans.*

(iii) The demand for the proposed benefit from the public and the source and extent of opposition to mandating the benefit.

Demand for Senate Bill 1094

Mandating insurance coverage of contraception has been a key issue for women's advocates and reproductive health professionals for some time. The Council received supportive submissions from women's advocacy groups, reproductive health advocates, research organizations, and reproductive professional organizations. Insurance coverage of the male impotence drug, Viagra, has given the movement new impetus within the last two years.

The Kaiser Family Foundation performed a national survey on insurance coverage of contraceptives in 1998.[16] The results are summarized below. In general, the level of support is dependent on the cost of coverage. Women (81%) are more likely than men (68%) to support the policy. Of those who favor contraceptive coverage, 82% think that all methods currently on the market should be covered.

	Strongly Favor	Somewhat Favor	Somewhat Oppose	Strongly Oppose
No Rise in Premium	45%	30%	8%	8%
$1-5 Rise in Monthly Premium	43%	30%	8%	12%
$20 Rise in Monthly Premium	30%	29%	13%	19%

Planned Parenthood of Western Pennsylvania submitted testimony that indicates that 90% of Americans support family planning to prevent unintended pregnancies, while two-thirds support requiring insurance policies to cover contraceptives. Copies of the surveys which resulted in these national figures were not submitted.

With no Pennsylvania specific figures submitted, there was insufficient information to estimate the precise level of demand in Pennsylvania.

Some opponent's submissions state that traditional fee-for-service contracts commonly provide coverage for contraceptives in the form of a "rider," suggesting that the number of employers choosing to purchase such a rider may be considered a proxy for demand for the benefit. The Insurance Federation notes that there is "very modest demand" for the inclusion of these riders by business purchasers. Capital Blue Cross reports that only 10% of its fee-for-service business customers have chosen to purchase the rider.

Proponents call this argument "illogical." The Women's Law Project points out that consumers often do not have a say in their employer's selection of insurance plans; therefore, an employer's decision to not purchase a rider should not be construed as representing lack of demand for the benefit. Insurance providers counter by suggesting that increased pressure on employers might have more favorable results than mandating coverage.

Opposition to Senate Bill 1094

Opponents are concerned because the coverage mandated in Senate Bill 1094 is tied to prescription drug coverage. Though employers recognize the importance of new pharmaceuticals in the treatment of many diseases, it may be beneficial to establish priorities. As the Employment Benefit Research Institute (EBRI) acknowledges,

> While prescription drug expenditures are rising sharply, they are also becoming more important in the treatment of many diseases. Consequently, both employer and policymakers must carefully balance the design and cost of a drug benefit so that continual innovation is preserved and the benefit can remain affordable and effective. [17]

The Employee Benefit Research Institute (EBRI) states that private insurance payments for prescription drugs increased 17.7 percent in 1997, after growing 22.1 percent in 1995 and 18.3 percent in 1996. These numbers compare to a 4 percent or less annual growth in private insurance payments for these same three years.[18] These increases are consistent with the experience of those Council members who purchase group health care benefits.

A universal theme among submissions from opponents is that businesses, especially small businesses, may be forced to forgo prescription drug coverage altogether in order to continue to offer a basic health insurance package to their employees. In a time of increased costs for prescription drug coverage, a mandate which adds to this trend may be mistimed.

Another source of opposition to SB 1094 are religious-based organizations who object to the lack of a "conscience clause", which would exempt employers or insurers whose religious beliefs conflict with the use of birth control. Of the ten states with mandates for contraceptives coverage, seven have included a religious exemption.

The Council received a submission from the Pennsylvania Catholic Health Association addressing this issue. Their submission states,

> The legislation would mandate coverage for services that are morally objectionable and contrary to Catholic Church teaching. The bill fails to provide any protection of religious employers….To force a Catholic employer to provide such coverage is a significant burden placed on the Church's religious freedom."

In opposition to this point, The Women's Law Project argues that,

> Employers or health insurance plans should not be allowed to refuse coverage based on any religious objection to birth control, because its employees or insured do not necessarily share that religious viewpoint.[19]

Opposition to Mandates in General

Most of the submissions opposing SB 1094 expressed strong opposition to mandates in general. Typically, opponents of mandates include insurers and purchasers of health care coverage, who argue that employers and their employees are in the best position to determine health care coverage options that are suited to their needs from a cost and quality standpoint. Bethlehem Steel Corporation makes the point that the bulk of their insured population is retirees and their spouses, a group not interested in contraception coverage.

Opposition to mandates in general is based on both cost and policy issues. Among the arguments made were that mandates increase the cost of health insurance and the number of uninsured, provide incentive for large employers to self insure, and have a disproportionate effect on small businesses. The point was made that any one mandate should be considered as contributing to the cumulative effect of mandates on businesses and on their ability to make affordable health insurance available to their employees. Workers end up paying for mandated benefits in the form of reduced wages or fewer benefits, as well as higher insurance premiums.

In support of these points, both Highmark and The Insurance Federation include a study from Milliman and Robertson which emphasizes the cumulative effect of mandates on the cost of health insurance, though it does not mention contraceptive coverage specifically. Milliman and Robertson estimated that the cost of 12 of the most common mandates can increase the cost of health insurance by as much as 30%.[20] Pennsylvania has already enacted over 25 mandates, including 6 of the 12 most common discussed by Milliman and Robertson.

A 1999 study by Jensen and Morissey, *The Price of State Mandated Benefits,* supports the contention that mandates cost money. Jensen and Morissey report that in Virginia, mandates accounted for 21% of claims; in Maryland they accounted for 11 to 22% of claims; and in Massachusetts 13% of claims.[21]

Opponents claim that the growing number of mandates hurts Pennsylvania's business climate. In general, the submissions from the business community point out that an increase in the cost of health care could encourage businesses to drop coverage for their employees, resulting in a rise in the number of uninsured.

Along these lines, the Kaiser Family Foundation reports that the number of small businesses (under 199 employees) providing health insurance for their workers has declined over the past several years. The study, conducted by KPMG Peat Marwick, found that the percentage of U.S. small business workers receiving employer sponsored health coverage declined from 52% in 1996 to 47% in 1998.[22] When employers who canceled their employees' health insurance policies have been polled on why they did so, the majority claimed that it was because the price was too high. Lower income employees are most likely to lose coverage. Insufficient information was submitted to determine whether these percentages are consistent with the experience in Pennsylvania.

The rise in the number of uninsured Pennsylvanians is an immediate and serious concern. The Health Insurance Association of America (HIAA) has reported that the number of uninsured under age 65 in Pennsylvania has jumped 34% since 1991, more than double the national increase of 16%.[23]

Jensen and Morrissey's report claims that between 20-25% of uninsured Americans lack coverage because of the cost of benefit mandates. Consumers may be forced into purchasing very expensive benefits or joining the ranks of the uninsured.[24]

The Women's Law Project claims that the argument that the cost of this mandate will lead to a greater number of uninsured is "without basis." Their submission cites a 1996 Lewin study which found that the majority (62.2%) of those who lose employment-based insurance coverage do so

because they or their spouse or parent lost their job. Only 4.1% lost coverage because their employer stopped offering health insurance.[25] Opponents might argue that *any* number of people who lost health insurance because their employer dropped coverage indicates that, in fact, employers *are* dropping health coverage, resulting in more uninsured.

Another point noted by opponents is that though increasing the cost of health insurance generally, mandates only benefit a limited percentage of Pennsylvania citizens. Because ERISA preempts self-insured firms from state mandates, a state mandate that applies to private group plans, will cover, on average only 33% of the state's population. One that applies to private group plans *and* individual policies will cover about 42% of a state's population. As the number of mandates increases, studies have indicated that more firms seek to self-insure to avoid being subject to mandates.[26]

In summary, opposition to the proposed legislation involves concerns about this legislation specifically as well as concerns about mandates in general. It is suggested that mandating coverage of contraception will raise the cost of pharmacy benefits. Even more to the point, purchasers and providers of health insurance are concerned about the impact of mandates on the number of Pennsylvanians without any health insurance, as well as having concerns about the cumulative effects of mandates on Pennsylvania's business climate.

(iv) All relevant findings bearing on the social impact of the lack of the proposed benefit.

Proponents argue that the lack of the proposed benefit has a major impact on the well being of Pennsylvania women. One point made is that access to contraception can result in healthier babies and fewer abortions.

Planned Parenthood of Western PA contends that coverage of contraceptives is not merely an economic issue but a public health issue. Their submission states that, according to the Institute of Medicine, a woman carrying an unintended pregnancy is less likely to seek early prenatal care. As a result, her baby is at greater risk for low birth weight and infant mortality. Furthermore, the National Commission to Prevent Infant Mortality estimates that infant deaths could be reduced by 10 percent and low birth weight could be reduced by 12 percent if all pregnancies were planned.[27]

On the other hand, several opponents challenge the idea that there is a social impact resulting from the lack of this mandate. These submissions contend that there is no indication that women in need of contraception are not able to obtain it due to lack of funds. It is also argued that providing insurance coverage for contraceptives does not guarantee that they will be used effectively and consistently. The point is made that there is no guarantee that access to coverage for contraceptives will result in fewer unintended pregnancies, since many of these pregnancies occur in women who report that they were using contraception. The Women's Law Project refutes this assertion, arguing that errors in using contraception can be attributed to women not utilizing the most effective methods because they are too expensive.

Another point made by proponents is that the proposed mandate would rectify a gender bias in health services. This assertion is based on the charge that women of reproductive age spend more than men on out-of-pocket health care cost, much of which is for reproductive health care services. Planned Parenthood of Western Pennsylvania, Inc. refers to the lack of insurance coverage for contraceptives as a "gender gap." According to the Women's Law Project, "Rectifying this gender inequity is worth what it would cost employers in health insurance costs, especially since it would be so little." [28]

One issue that several submissions noted was the insurance coverage of the male erectile dysfunction drug Viagra. Proponents argue the point that if health insurance covers the enhancement of a male's sex life, it ought to cover contraception as well. The National Abortion

& Reproductive Rights Action League of Pennsylvania (NARAL-PA), in its fact sheet, *Coverage for Contraception*, notes that in its first month on the market Viagra was covered more often than birth control, which has been on the market for more than 30 years.[29]

Opponents' submissions challenge the notion that lack of the proposed benefit results in unfairness to women. Highmark points out that their insurance products offer Viagra coverage only as an optional rider, as is the case with oral contraceptives. Capital Blue Cross maintains that their plans cover oral contraceptives when they are prescribed for medically necessary purposes – similarly, Viagra is covered when it is medically necessary.

Capital Blue Cross contends that, for medically necessary purposes, gender specific drugs are covered on an equal basis, noting, "The fact is that there are many gender-specific drugs for both men and women. And where those drugs are deemed medically necessary to treat a disease or condition, they are covered by health insurance without regard to gender utilization."

The Women's Law Project claims that some insurers do not cover contraception even when prescribed for medically necessary reasons other than birth control. They cite informational literature from Oxford, a health plan which has no commercial members in Pennsylvania, but is one of the Medicaid HMOs authorized by the Pennsylvania Department of Welfare for administering coverage for Medicaid recipients (Medicaid covers all five prescription methods of contraception).[30]

Opponents also make the point that if the cost of the mandate results in their employer dropping prescription drug coverage, all women, not just those who purchase contraceptives, will lose a valuable benefit.

While both made general assertions of social impact, neither proponents nor opponents submitted concrete evidence to thoroughly support their points.

(v) Where the proposed benefit would mandate coverage of a particular therapy, the results of at least one professionally accepted, controlled trial comparing the medical consequences of the proposed therapy, alternative therapies and no therapy.

The proposed benefit does not mandate coverage of a therapy.

(vi) Where the proposed benefit would mandate coverage of an additional class of practitioners, the result of at least one professionally accepted, controlled trial comparing the medical results achieved by the additional class of practitioners and those practitioners already covered by benefits.

The proposed benefit does not mandate coverage of an additional class of practitioners.

(vii) The results of any other relevant research.

All research and analysis relevant to this issue is included elsewhere in this report.

(viii) Evidence of the financial impact of the proposed legislation, including at least:

(A) The extent to which the proposed benefit would increase or decrease cost for treatment or service.

None of the submissions received by the Council directly addressed this issue. However it may be conjectured that if insurance coverage for contraceptives were mandated, insurance companies may be able to negotiate lower prices for contraceptive drugs and devices. Since no information related to this issue was submitted, no projections can be made.

(B) The extent to which similar mandated benefits in other states have affected charges, costs and payments for services.

The legislation passed in other states has, for the most part, been passed within the last year. For this reason, it is too early to make a reliable determination of cost based on experience in other states.

Maryland became the first state to enact legislation mandating the coverage of reversible prescription contraceptives in 1998. As of December 1999, nine more states had passed legislation relating to comprehensive coverage of contraceptives. These states are California, Connecticut, Georgia, Hawaii, Maine, Nevada, New Hampshire, North Carolina and Vermont. All of these states, with the exception of Hawaii, tie birth control coverage to the provision of prescription drug benefits. Hawaii's measure states that contraceptive coverage must be provided as a companion to pregnancy-related benefits. All of these state laws cover contraceptive drugs and devices. Hawaii, Maine, Maryland, Nevada, North Carolina, New Hampshire and Vermont also explicitly include the coverage of services related to the provision of contraceptives – counseling, exams and insertion/removal, as would Senate Bill 1094.

A number of states – Idaho, Iowa, Kentucky, New Jersey, Virginia and West Virginia – require that insurers offer contraception coverage as an option. In Minnesota, regulations require HMOs to cover contraceptive drugs. Texas has adopted an administrative rule mandating the coverage of birth control pills.[31]

On December 1, 1999, Maryland's Health Care Access and Cost Commission (HCACC) released a report evaluating the cost of current and proposed mandates, "Mandated Health Insurance Services Evaluation." The HCACC contracted with William Mercer, Inc., a benefits consultant, to prepare the report. This report estimated the annual full cost of the mandate to be $9 per group policy. The marginal cost, defined to be the full cost of the benefit minus the value of the services that would be covered in the absence of the mandate, was estimated to be $5 annually. It should be noted that in Maryland, mandates apply only to employers with more than 50 employees. The situation is somewhat different in Pennsylvania, where the legislation will impact a larger population, including small businesses and individual policies.[32]

(C) The extent to which the proposed benefit would increase the appropriate use of the treatment or service.

Proponents contend that since cost is a barrier to access, it follows that removing this barrier would result in more utilization.

It was also argued that the proposed benefit would result in more *appropriate* use of contraceptives. Planned Parenthood of Western Pennsylvania notes that women may choose their second or third choice in contraception because of cost, which may mean a less effective method, or one that might not be best for them for health reasons.

Opponents differed in whether they project greater utilization of contraceptives as a result of the proposed mandate. Several opponents maintain that there is no evidence to suggest that

mandating coverage of contraceptives would induce women to use birth control or reach any substantial number of women who do not currently have access and the means to afford contraception.

Another opponent, in contrast, speculates that utilization of prescription contraception will increase as a result of the mandate. It is probable that new methods of birth control will be approved by the FDA in future years, all of which would be covered by this mandate.

Proponents make the point that the paying for contraception will result in *more appropriate* utilization. Opponents, on the other hand, claim that there is no guarantee that the proposed benefit will result in *more appropriate* utilization. They contend that there are already a number of avenues for women to obtain contraception.

Though proponents cited several studies, copies of these studies were not submitted. Opponents submitted neither data nor studies to support their claims.

(D) The impact of the proposed benefit on administrative expenses of health care insurers

Highmark notes that they expend hundreds of man-hours in preparation for adding a new benefit. Computer systems must be updated, benefits booklets and summary plan descriptions must be revised, and groups must have the information about the new benefit communicated to them. Highmark estimates they will expend a total of $21.4 million annually in administering SB 1094, ten percent of their projected overall financial impact. Highmark bases this figure on an analysis of current claims and projected claims beyond existing coverage for all Highmark companies, including its managed care subsidiaries as well as the three Blue Cross plans.

The cost estimate in the report commissioned by The Alan Guttmacher Institute includes administrative expenses. 15.5% was added to the base cost of the coverage to arrive at the final figure of $21.40 per employee per year.[33]

No other submissions included information on administrative costs. Given the information provided above, neither supporters nor opponents of the bill provided the Council with sufficient information which could be used to estimate the precise impact of the proposed benefit on administrative expenses of health care insurers.

(E) The impact of the proposed benefits on benefits costs of purchasers.

Proponents and opponents cited a small number of sources in regard to cost estimates. These analyses are summarized below. Some of these estimates utilize a "per member" figure, while others utilize a "per employee" figure. Given this disparity, the numbers are difficult to reconcile. All of the estimates project an increase in premiums, though to varying degrees. The difference between the presentation of proponents and opponents is that opponents feel that the increases projected are major, while the proponents view projected increases as insignificant. Only one of these studies, the Alan Guttmacher Institute study, is a published actuarial study. Though the estimates in this study are used as a basis for discussion, additional studies for comparison are necessary before estimates for Pennsylvania can be made with confidence.

- A 1998 study commissioned by The Alan Guttmacher Institute, estimated the total cost of covering contraceptives for employees and their dependents to those plans that do not currently cover them to be $21.40 per employee per year – $17.12 of employers' costs and $4.28 of employees' costs. The Alan Guttmacher Institute submission states that this translates to a .6% increase of employers' overall insurance costs.[34]

- One submission reports that in 1996, the Health Insurance Association of America (HIAA) estimated that the cost of adding contraceptive coverage (*for oral contraceptives*

only) to a drug plan would be $16.20 per employee per year. This figure does *not* include the cost of covering the other non-permanent methods – diaphragms, IUDs, injectables and implants.

- Capital Blue Cross reports that a preliminary internal projection indicates a cost of between $1.50 and $3.00 per member per month, or $18 - $36 per member per year. This preliminary internal estimate does not include co-insurance or deductibles.

- The Insurance Federation states that the cost of Aetna U.S. Healthcare's contraceptive coverage rider in 1999 was $30 to $36 per person per year depending on the copayment. The Insurance Federation acknowledges that the cost of this benefit should be less because the employee pool supporting it should be larger.

- The Insurance Federation reports that Educators Mutual's actuary calculated that contraceptives can be 6 percent of prescription costs under a prescription drug benefit. Since prescription drug costs are currently approximately 15 percent of total health care cost, the cost for contraceptives translates to .9 percent of total health care costs.

(F) The impact of the proposed benefits on the total cost of health care within the Commonwealth.

Proponents and opponents differed in their perspective on how this mandate would affect the total cost of health care within the Commonwealth. Proponents' submissions included information related to possible savings secondary to fewer pregnancies. On the other hand, opponents looked at dollar costs of the legislation, rising pharmacy costs and potential consequences of increasing the expense of health insurance for employers, including the possibility of increasing the number of uninsured.

Proponents Discuss Potential Cost Savings Resulting From Contraception Coverage

Proponents argue that coverage for a full range of contraceptive methods will lead to substantially more effective contraceptive use, resulting in savings in costs associated with unintended pregnancies.

According to the Centers for Disease Control and Prevention, nationally nearly half of all pregnancies are unintended. Proponents' submissions contain the information that 51% of unintended pregnancies in the United States end in abortion (NIH's Committee on Unintended Pregnancy).[35] Insurers already pay for the half of all unintended pregnancies that end in deliveries. As a basis for discussion, national percentages may be utilized, since Pennsylvania-specific rates of unintended pregnancy and abortion were not submitted.

Estimated savings from avoiding "unwanted pregnancies." Based on national statistics, it can be hypothesized that in Pennsylvania the number of unintended pregnancies in 1997 may have been approximately 90,508 (50% of 181,016)[†] Of these unintended pregnancies, approximately 44,348 (49%) ended in delivery. (Committee on Unintended Pregnancy, National Institute of Medicine) According to the Women's Law Project submission, 14% of the unintended pregnancies are "unwanted" as opposed to "mistimed." Prevention of "mistimed" pregnancies would not result in savings, since these pregnancies would merely be postponed. If is assumed that 14% of the unintended pregnancies that ended in delivery were "unwanted" and would be

[†] The Council utilized the pregnancy, abortion, and live birth rates reported by the Pennsylvania Department of Health because there is no information on whether the estimated number of early miscarriages included by the CDC is occurring in insured women, whether they are unintended or unwanted pregnancies or whether they are incurring any significant medical cost. See discussion on page 4.

prevented by this legislation, theoretically a savings of approximately $36 million could be realized. (14% of 44,348 – a total of 6,208 deliveries at an average cost of $5,800)[‡]

Estimated savings from minimizing low birth weight babies. A further savings cited by The Women's Law Project is in the prevention of low birth weight babies, saving between $14,000 and $30,000 per baby. The National Commission to Prevent Infant Mortality estimates that low birth weights could be reduced by 12 percent if all pregnancies were planned. According to the Pennsylvania Health Care Cost Containment Council data, there were 9,587 low-weight births (below 2,500 grams) in Pennsylvania in 1998. Of this number, 2,913 low birth weights occurred in the Medicaid population, a population which currently *has* coverage for all five contraceptive methods. SB 1094, therefore, would not affect low weight births occurring in the Medicaid population. If the remainder (6,674 low weight births) were reduced by 12 percent (801 babies), a possible savings of $17.6 million can be conjectured (801 babies at an average cost of $22,000 per low weight birth).[††]

Estimated savings from minimizing abortion. The Women's Law Project cites savings due to the prevention of abortions. It is not known how many abortions may be prevented by this legislation, since no studies addressing this issue were submitted. The Women's Law Project makes an estimate assuming that all of Pennsylvania's abortions could be prevented. While it is fair to assume *some* savings, an estimate assuming 100% has little validity. For the purposes of making a projection, if it is assumed that 50% of Pennsylvania's 35,478 abortions could be prevented, the result is a possible savings of $7.4 million (using an average cost of $416 per abortion). Furthermore, an assumption of *any* savings resulting from preventing abortions has little foundation, since it is not known how many of the 35,478 abortions in Pennsylvania were performed on women in the population affected by this mandate (those covered by private health insurance), and how many of those abortions were actually *covered* by private health insurance, since many plans cover only those abortions meeting certain criteria.

While there is little question that some corresponding savings will occur, in viewing the available data, it appears that making an estimate of savings would, at this juncture, be a speculative endeavor for Pennsylvania, especially those savings related to preventing abortions. No numbers specific to Pennsylvania were submitted concerning what percentage of pregnancies in Pennsylvania are unintended (and unwanted). More importantly, we have no information specific to *the population covered by this legislation (women who are covered by private health insurance).*

Opponents Predict Large Costs Statewide

Only one actuarial study concerning the cost of covering contraceptives was submitted: *Cost to Employer Health Plans of Covering Contraceptives*, commissioned by The Alan Guttmacher Institute. This study was cited in the submissions of both proponents and opponents. Because this study was the only actuarial study submitted, its cost estimates are used as a basis for discussion. Without other supportive studies, statewide health care costs arrived at by using these estimates are tentative.

This study estimates that the average total cost (including administrative costs) of adding coverage for reversible prescription contraceptives to health plans that currently do not cover them will be an increase of $21.40 per employee per year – $17.12 of *employers'* costs and $4.28

[‡] The Women's Law Project projects higher figures for savings in avoiding unintended pregnancy ($88 million). Their numbers are based on an assumption of 148,000 unintended pregnancies from the CDC estimates. The 90,508 figure we used was derived from Pennsylvania Department of Health data. See page 4 for a discussion of this issue. The $88 million put forth by The Women's Law Project is also based on a delivery cost of $8,619, the highest of the range of estimates we received. We utilized an average of the highest and the lowest estimates of delivery cost ($3,000 - $8,619 = an average of $5,800).

[††] The Women's Law Project projects a savings of between $18 million and $39 million, based on an assumption of 11,000 low birth weight babies.

of *employees'* costs. The submission states that this figure comprises about .6% of employers' health insurance costs. The majority of this amount is for oral contraceptives.

Only the cost of *contraceptive supplies* was covered by this estimate. The cost of outpatient counseling was considered to be part of a routine office visit. The *per employee* costs includes costs for the employee as well as for any spouse or other dependents.

In attempting to estimate how this figure ($21.40 per employee) translates into total cost, the following information from The Employee Benefits Research Institute (EBRI) was used. EBRI estimates that approximately 43.5% of Pennsylvania's population has coverage *in their own name* (36% have employment-based insurance in their own name and 7.6% of the population has an individual policy).[36] When this figure ($21.40 per employee per year) is applied to the approximate number of Commonwealth citizens who would be impacted by this legislation (5,220,631 covered by private insurance *in their own name*, about half of which are in ERISA exempt plans, resulting in approximately 2,610,315 members who would be impacted by the mandate), the cost for one year in Pennsylvania is estimated to be about $55.8 million. This study assumes an employee co-payment of $11.1 million, resulting in a cost of $44.7 million to employers. This does not include the cost of methods currently being developed which would be covered by this legislation, nor does it include the cost of outpatient services.

It is difficult to reconcile the cost figure noted above with other information submitted because insurance companies utilize "per member" calculations to arrive at cost figures. For example, Capital Blue Cross' preliminary internal estimates ranged from $1.50 to $3.00 per *member* per month, or $18 - $36 per *member* per year. If these cost figures were applied to the population affected by this mandate (8.1 million *members* covered by private health insurance – including dependents – about half of which are in ERISA exempt plans, resulting in approximately 4 million members who would be impacted by the mandate), the result is a statewide yearly cost which ranges between $72.9 million and $145.8 million. Information used to derive the $1.50 - $3.00 range was not submitted, but the cost provided by Capital Blue Cross is somewhat similar to the cost of Aetna's contraceptive coverage rider ($30 - $36 per member per year).

Highmark was the only submitter that put forward a predicted statewide cost estimate. Highmark actuaries project a cost of $213.8 million for Highmark and the three Blue Cross plans (Independence Blue Cross, Capital Blue Cross and Blue Cross of Northeastern Pennsylvania). Their estimate for the rest of the state (commercial health insurers) is a total of $197 million. The Highmark submission concludes that a statewide total cost for contraceptive coverage would be $411 million. The Highmark submission did not include specific information regarding how these estimates were calculated (number of claims, cost per claim, etc.).

Highmark's estimates take into consideration the possibility of new types of birth control being developed, as well as assuming higher utilization than the current level. Since the legislation states that all methods with FDA approval are to be covered, it is not possible to ascertain exactly how many or what type of contraceptive methods may be included in the mandate in the future. Highmark's submission includes information about a male contraceptive currently being studied, which consists of a combination of a pill and a testosterone patch. Should such a method obtain FDA approval, use of prescription contraception would be applicable to men as well as women, thus doubling the population of potential users.

The Pennsylvania Chamber of Business and Industry claims that Pennsylvania businesses currently spend about $10 billion a year to provide health care coverage to their employees. Using a percentage advanced by proponents of the total cost of providing health care coverage to employees (.6%), the yearly cost to Pennsylvania businesses may increase by about $60 million.[37] This total cost figure does not include the amounts spent on individual policies. Applying the .9% total cost figure quoted by The Insurance Federation, the yearly cost increase to Pennsylvania businesses rises to approximately $90 million.

Other opponents refer to the cost analyses described earlier and maintain that there will be an increase in costs statewide. In general, specific numbers were not submitted. The Insurance Federation comments,

> The mandated benefits proposed will have a major, negative financial impact on purchasers of health insurance. The exact cost of imposing these requirements on the pool of policies subject to them is not calculable at present….Regardless, by rough calculations by both proponents and opponents the cost is going to be significant.

The Managed Care Association states,

> While the cost of the mandate specified in Senate Bill 1094 may not be significant to purchasers who utilize managed care plans which already generally cover the cost of contraceptives through prescription drug riders, it is the cumulative cost of all mandates that impacts the affordability of health care.

The cost figures submitted present an unclear picture. Though most figures project an increase in health premiums, the amount of the projected increase varies considerably. Reconciling the cost figures is difficult in the absence of more than one published actuarial study. One published study is not sufficient evidence upon which to base reliable estimates of the financial impact of this legislation.

Other Cost Concerns

A number of opponents point out that the cost of prescription drug coverage is rising at a considerable rate and question whether this is the time to add a mandate that will increase the cost of prescription drug coverage.

Opponents are emphatic about the danger of instituting a large number of mandates in the Commonwealth. They point to studies which indicate that as health insurance costs go up, the number of uninsured Pennsylvanians increases as well. A rising number of uninsured Pennsylvanians will have a major impact on the financial health of the health care delivery system. The cost of cumulative mandated benefits to Pennsylvania's economy and business climate are serious issues which must be balanced with the benefits of any particular mandate. Opponents argue that attention needs to turn to addressing the needs of Pennsylvania's citizens who are locked out of basic health care coverage rather than adding more layers of coverage benefiting a comparatively smaller number of people.

References

[1, 3, 4, 6] Kaiser Family Foundation. "Contraception in the 90's." http://www.kff.org.

[2] The Alan Guttmacher Institute. "Contraception Counts: Pennsylvania Information." http://www.agi-usa.org

[5, 8, 19, 28] The Women's Law Project. "Testimony of The Women's Law Project Before the Health Care Cost Containment Council in Support of S.B. 1094." January 20, 2000.

[7, 33, 34, 37] Darroch, Jacqueline, Ph.D. "Cost to Employer Health Plans of covering Contraceptives." *The Alan Guttmacher Institute*. June 1998.

[9, 25] The Women's Law Project. "Reply of The Women's Law Project To Statements of Opponents of S.B. 1094." March 13, 2000.

[10] The Managed Care Association of Pennsylvania . Comments submitted in opposition to S.B. 1094. January 19, 2000.

[11] Planned Parenthood. "Testimony In Support of S.B. 1094." January 18, 2000.

[12, 27] Planned Parenthood of Western Pennsylvania. *Testimony of Kimberlee Evert, MPH.* November 3, 1999.

[13] The Alan Guttmacher Institute. "Statement of Jacqueline Darroch, Ph.D., Senior Vice President and Vice President for Research." January 19, 2000

[14] Pennsylvania Department of Health, Bureau of Managed Care.

[15] Pennsylvania Department of Public Welfare.

[16] Kaiser Family Foundation. "Americans Support Requiring Insurers To Cover Contraceptives, Even If Premiums Rise." http://www.kff.org/content/archive/1404/insurance

[17, 18] Employee Benefit Research Institute. "Prescription Drugs: Issues of Cost, Coverage, and Quality." *EBRI Issue Brief Number 208.* April, 1999.

[20] National Center for Policy Analysis. "The Cost of Health Insurance Mandates." *Brief Analysis No. 237*. April 1999.

[21, 24, 26] Jensen, Gail, Ph.D. and Morrisey, Michael, Ph.D. "Mandated Benefit Laws and Employer-Sponsored Health Insurance." *The Health Insurance Association of America*. January, 1999.

[22] Hamilton, Martha. "Health Care Coverage Declines at Small Firms." *The Washington Post.* February 24, 1999.

[23] The Patriot News. "Pennsylvania's Rate of Uninsured Rises Dramatically." January 24, 2000.

[29] NARAL-PA Foundation. "Coverage for Contraception."

[30] Pennsylvania Department of Health, Bureau of Managed Care.

[31] National Conference of State Legislatures. "Health Insurance Coverage for Contraceptives." http://www.ncsl.org/programs/health/contrace.htm

[32] William Mercer, Inc. "Mandated Health Insurance Services Evaluation." *Maryland Health Care Access and Cost Commission*. December 15, 1998. http://www.mhcc.state.md.us.

[35] The Centers for Disease Control and Prevention. "The 1996 Pregnancy Risk Assessment Monitoring System Surveillance Report." 1997. http://www.cdc.gov.

[36] Employee Benefit Research Institute. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1999 Current Population Survey." *EBRI Issue Brief Number 217*. January, 2000.

Submissions for Senate Bill 1094

AFLAC – American Family Life Assurance Company of Columbus (Mr. Richard Gmerek of the Law Office of Gmerek & Hayden, P.C.)

1. Statement addressing SB 1094 and requesting exemptions for certain supplemental policies.

The Alan Guttmacher Institute (Jacqueline E. Darroch, PHD, Senior Vice President & Vice President for Research)

1. The Alan Guttmacher Institute. "The "Cost to Employer Health Plans of Covering Contraceptives." June 1998.
2. Darroch, Jacqueline E., PHD. "Statement Submitted to The Pennsylvania Health Care Cost Containment Council in Support of Pending Legislation, The Prescription Contraception Equity Act." January 19, 2000.

The American College of Obstetricians and Gynecologists (Peter A. Schwartz, MD, Chairman of the Pennsylvania Section)

1. Letter addressing Section 9 requirements and supporting SB 1094.
2. "Pennsylvania Insurance Coverage of the Five Most Commonly Used Methods of Births Control".
3. The Alan Guttmacher Institute. "Cost to Employer Health Plans of Covering Contraceptives." June 1998.
4. "Non-pregnancy related health benefits of contraception."
5. NARAL-PA Foundation. "Coverage for Contraception"
6. The American College of Obstetricians and Gynecologists. "Statement on Contraceptive Methods." July 1998.

Bethlehem Steel Corporation (Ms. Dorothy L. Stephenson, Vice President, Human Resources)

1. Letter opposing SB 1094.

Capital Blue Cross (Mr. Vincent P. Carocci, Director of Government Affairs)

1. Letter addressing Section 9 requirements and opposing SB 1094.

Family Health Council, Inc. (Maureen Vesely, JD, Public Affairs Coordinator)

1. Letter addressing Section 9 requirements and supporting SB 1094.
2. Marazzo, Donald, MD, MPH. Testimony in support of SB 1094.

Highmark (Mr. Bruce Hironimus, Vice President, Government Affairs)

1. Letter opposing SB 1094.
2. Statement addressing Section 9 requirements and opposing SB 1094.
3. Bureau of the Census. "Fertility Indicators for Women 15 to 44 Years Old by State of Residence." November 25, 1997. http://www.census.gov.
4. Employee Benefit Research Institute. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1999 Current Population Survey." *EBRI Issue Brief Number 217*. January, 2000.
5. The National Abortion & Reproductive Rights Action League of Pennsylvania (NARAL-PA). "Promoting Reproductive Choices."
6. National Conference of State Legislatures. "Health Insurance Coverage for Contraceptives." http://www.ncsl.org/programs/health/contrace.htm

7. American Association of Health Plans (AAHP). "Mandatory Contraceptive Coverage Approved in Four More States: Legislation Pending in 11 States." *In the States, June 25, 1999.*
8. AVSC International. "Contraception." http://www.avsc.org.
9. Bovo, Mary Jane, MD. "Contraceptive Guide." April 1999. http://www.mjbovo.com.
10. Employee Benefit Research Institute. "Prescription Drugs: Issues of Cost, Coverage, and Quality." *EBRI Issue Brief Number 208.* April, 1999.
11. Blue Cross Blue Shield Association. "Pharmacy Fast Facts, Rx Trends and Stats." October 1999.
12. Merrill, Richard A. "Modernizing the FDA: An Incremental Revolution." *Health Affairs 18(2):96-111.*
13. Health Care Financing Administration (HCFA). "Highlights, National Health Expenditures, 1998." http://www.hcfa.gov.
14. Reese, Shelly. "Can Employers Halt the Price Hikes?" *Business & Health, December 1999.*
15. American Association of Health Plans. "Formularies." *Health Policy Issue Brief, May 1998.*
16. Goldberg, Carey. "Seeking Viagra Equity, More States Requiring Insurers to Cover Contraception." *New York Times, June 30, 1999.*
17. National Center for Policy Analysis. "The Cost of Health Insurance Mandates." *Brief Analysis No. 237, August 13, 1997.*
18. Thorpe, Kenneth E. and Florence, Curtis S. "Why Are Workers Uninsured? Employer-Sponsored Health Insurance in 1997." *Health Affairs18(2): 213-28.*
19. Employee Benefit Research Institute. "Employment-Based Health Benefits: Who Is Offered Coverage vs. Who Takes It." *EBRI Issue Brief No. 213.* September 1999.
20. Hamilton, Martha. "Health Care Coverage Declines at Small Firms." *The Washington Post.* February 24, 1999.
21. Levit, Katharine, et al. "Health Spending in 1998: Signals of Change." *Health Affairs 19(1): 124-132.*
22. Personal Insurance Center. "Pill Bills: State That Mandate Contraceptive Equity." http://www.drkoop.com.
23. Reuters Health. "Pill/Patch Male Contraceptive Promising." June 8, 1999. http://www.allhealth.com.
24. Jensen, Gail, Ph.D. and Morrisey, Michael, Ph.D. "Mandated Benefit Laws and Employer-Sponsored Health Insurance." *The Health Insurance Association of America*. January, 1999.
25. Towers Perrin. "Analysis of Health Care Mandates and Controls." *The Minnesota Council of Health Plans, The Minnesota Chamber of Commerce, The Minnesota Business Partnership.* March 18, 1999.
26. Seward, J. Allen, PHD and Henderson, James W., PHD. "Report on the Cost of Health Care System Mandates." *Baylor University*. January 1999.
27. Hilzenrath, David S. "Health Costs Hitting Small Firms Harder." *The Washington Post, December 14, 1999.*
28. Geisel, Jerry. "Health Costs Jump; 7.3% in '99: Study." *Business Insurance, December 13, 1999.*

The Insurance Federation of Pennsylvania, Inc. (Mr. John R. Doubman, Secretary & Counsel)

1. Statement in opposition to SB 1094 and addressing Section 9 requirements (January 30, 2000).
2. Statement addressing submissions of proponents (March 10, 2000).
3. National Center for Policy Analysis. "The Cost of Health Insurance Mandates." *Brief Analysis No. 237, August 13, 1997.*

Managed Care Association of Pennsylvania (Ms. Kimberly J. Kockler, Executive Director)

1. Statement addressing Section 9 requirements and opposing SB 1094.
2. Gavora, Carrie. "How Health Insurance Mandates Misdiagnose the Disease." *The Heritage Foundation Backgrounder.* April 10, 1997.

National Federation of Independent Business (Mr. James D. Welty, Pennsylvania State Director)

1. Letter opposing SB 1094.

Pennsylvania Catholic Health Association (Sister Clare Christi Schiefer, OSF, President)

1. Letter opposing SB 1094.

Pennsylvania Chamber of Business and Industry (Mr. Fred A. Sembach, Vice President, Government Affairs)

1. Letter opposing SB 1094.

Planned Parenthood (Ms. Nancy J. Osgood, Acting Executive Director)

1. Letter supporting of SB 1094.
2. Testimony addressing Section 9 requirements and supporting SB 1094.

Planned Parenthood of Western Pennsylvania, Inc. (Ms. Jodi, Hirsh, Public Affairs Coordinator)

1. Letter supporting SB 1094.
2. Testimony of Kimberlee Evert, MPH, President of Planned Parenthood of Western Pennsylvania, Inc.
3. The Alan Guttmacher Institute. "Cost to Employer Health Plans of Covering Contraceptives." June 1998.
4. William M. Mercer, Inc. "Mandated Health Insurance Services Evaluation." Health Care Access and Cost Commission. December 15, 1998.

Women's Law Project (Tara S. Crean, Esq., Susan Frietsche, Esq. and Terry L. Fromson, Esq.)

1. Statement addressing Section 9 requirements and supporting SB 1094 (January 20, 2000)
2. Reply to Statement of Opponents of SB 1094 (March 13, 2000).

PRINTER'S NO. 1330

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1094 Session of 1999

INTRODUCED BY SCHWARTZ, KUKOVICH, EARLL, HUGHES, KITCHEN AND DENT, SEPTEMBER 24, 1999

REFERRED TO BANKING AND INSURANCE, SEPTEMBER 24, 1999

AN ACT

To ensure equitable coverage of prescription contraceptive drugs and devices and the medical and counseling services necessary for their effective use.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Short title.

This act shall be known and may be cited as the Prescription Contraception Equity Act.

Section 2. Findings.

The General Assembly finds and declares as follows:

(1) Each year, approximately 3,600,000 women face an unintended pregnancy, representing nearly half of all pregnancies in the United States.

(2) By reducing rates of unintended pregnancy, contraception improves women's health and well-being, reduces infant morbidity and mortality and reduces the need for abortion.

(3) The cost of adding insurance coverage for all FDA-

approved contraception and related medical and counseling services is estimated at $1.78 per employee per month.

(4) To defray their medical expenses, most women in the United States, including two-thirds of women of childbearing age, rely on some form of private, employment-related insurance which they receive through either their own employer or a family member's employer.

(5) Although 97% of typical fee-for-service insurance policies written for large groups or preferred provider organizations cover prescription drugs and 92% of these policies cover prescription medical devices, including drugs and devices used exclusively by men, 49% of these policies cover no reversible method of contraception at all. Moreover, only 15% of these policies cover all five methods of FDA-approved contraception.

(6) Although the vast majority of typical fee-for-service insurance policies written for large groups or preferred provider organizations cover outpatient medical and counseling services, the majority of these policies fail to cover outpatient medical and counseling services necessary for the effective use of contraception.

(7) Health insurance policies that fail to cover prescription contraception and related medical and counseling services discriminate against women and place effective forms of contraception beyond the financial reach of many families. Women of reproductive age spend 68% more than men on out-of-pocket health care costs. Contraceptive drugs, devices and related medical and counseling services account for much of this difference.

(8) This act affects the business of insurance. The

requirements of this act govern entities within the insurance industry that provide health insurance policies as defined by this act. The provisions of this act transfer and spread an insured's risk and are an integral part of the policy relationship between the insurer and the insured.

Section 3. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Health insurance policy." A policy, agreement, contract, certificate, indemnity plan, suretyship or annuity issued, proposed for issuance or intended for issuance by an insurer, including endorsements, supplements or riders to an insurance policy, contract or plan, that provides health coverage to an insured and that is issued, delivered, amended or renewed in this Commonwealth on or after the effective date of this act. The term does not include short-term travel or accident-only policies, workers' compensation or short-term nonrenewable policies of not more than six months' duration. A policy located or documented outside this Commonwealth is subject to the requirements of this act if it receives, processes, adjudicates, pays or denies claims for drugs, devices or medical or counseling services submitted on behalf of an insured who resides in or receives drugs, devices or services in this Commonwealth.

"Insured." A party named on a health insurance policy, including an individual, corporation, partnership, association, unincorporated organization or any similar entity, as the person

with legal rights to the coverage provided by the health insurance policy. For group insurance, the term includes a person who is a beneficiary covered by a group health insurance policy.

"Insurer." An individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, fraternal benefit society and any other legal entity engaged in the business of insurance, including agents, brokers, adjusters and third-party administrators. The term also includes a person who contracts on a risk-assuming basis to provide, deliver, arrange for, pay for or reimburse any of the cost of health care services, including, but not limited to, health plan corporations as defined in 40 Pa.C.S. Chs. 61 (relating to hospital plan corporations) and 63 (relating to professional health services plan corporations), beneficial societies as defined in 40 Pa.C.S. Ch. 67 (relating to beneficial societies), fraternal benefit societies as defined in the act of December 14, 1992 (P.L.835, No.134), known as the Fraternal Benefit Societies Code, health maintenance organizations as defined in the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act, and preferred provider organizations as defined in section 630 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, and 31 Pa. Code § 152.2 (relating to definitions).

"Limitation." Any of the following:

(1) Any copayment, deductible or other cost-sharing mechanism, or premium differential, rules or regulations that establish the type of professionals that may prescribe prescription drugs or devices, utilization review provisions and limits on the volume of prescription drugs or devices

that may be obtained on the basis of a single consultation with a professional.

(2) Requirements or procedures relating to timing of payments or reimbursement by insurers

(3) Requirements relating to second opinions or preauthorizations prior to coverage.

"Outpatient medical or counseling services necessary for the effective use of contraception." The term includes, but is not limited to, examinations, procedures and medical and counseling services provided on an outpatient basis, and services for initial and periodic comprehensive physical examinations, medical, laboratory and radiology services warranted by the initial and periodic examinations or by the history, physical findings or risk factors, including medical services necessary for the insertion and removal of any contraceptive drug or device and individual or group family planning counseling. Coverage for the comprehensive health exam shall be consistent with the recommendations of the appropriate medical specialty organizations and shall be made under terms and conditions applicable to other coverage.

"Prescription contraceptive drug or device approved by the Food and Drug Administration." Any regime of a prescription contraceptive drug and any regime of a prescription contraceptive device approved by the Food and Drug Administration, as well as any generic equivalent approved as substitutable by the Food and Drug Administration.

Section 4. Requirements for coverage.

A health insurance policy shall not:

(1) Exclude or restrict coverage for any prescription contraceptive drug approved by the Food and Drug

Administration, if the policy provides coverage for other prescription drugs.

(2) Exclude or restrict coverage for a prescription contraceptive device approved by the Food and Drug Administration, if the policy provides coverage for other prescription devices.

(3) Exclude or restrict coverage for outpatient medical or counseling services necessary for the effective use of contraception, if the policy provides coverage for other outpatient medical or counseling services.

(4) Deny to any individual eligibility or continued eligibility to enroll or to renew coverage under the terms of the policy because of the individual's past, present or future use of contraceptive drugs, devices or medical or counseling services that are required by this act.

(5) Provide monetary payments or rebates to an insured to encourage the insured to accept less than the minimum coverage required by this act.

(6) Penalize or otherwise reduce or limit the reimbursement of a health care professional because that professional has in the past or will in the future prescribe contraceptive drugs or devices, or provide medical or counseling services that are required by this act.

(7) Provide monetary or other incentives to a health care professional to withhold from an insured contraceptive drugs or devices or medical or counseling services that are required by this act.

Section 5. Construction.

Nothing in this act shall be construed as:

(1) Preventing a health insurance policy from imposing a

limitation in relation to:

(i) Coverage for prescription contraceptive drugs, provided that the limitation for this coverage is not greater than or different from limitations imposed under general terms and conditions applicable to all other prescription drugs covered under the policy.

(ii) Coverage for prescription contraceptive devices, provided that the limitation for this coverage is not greater than or different from limitations imposed under general terms and conditions applicable to all other prescription devices covered under the policy.

(iii) Coverage for outpatient medical or counseling services necessary for the effective use of contraception, provided that the limitation for this coverage is not greater than or different from limitations imposed under general terms and conditions applicable to all other outpatient medical or counseling services covered under the policy.

(2) Requiring a health insurance policy to cover experimental prescription contraceptive drugs or devices or experimental outpatient medical or counseling services necessary for the effective use of contraception, except to the extent that the policy provides coverage for other experimental prescription drugs or devices or experimental outpatient medical or counseling services.

(3) Requiring coverage for prescription contraceptive drugs, devices or medical or counseling services required by this act in any policy that does not otherwise provide coverage for prescription drugs or devices or outpatient medical or counseling services.

Section 6. Enforcement.

(a) Action by applicant.--An applicant or an insured who believes that he has been adversely affected by an act or practice of an insurer in violation of this act may:

(1) file a complaint with the commissioner, who shall handle the complaint consistent with 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies) and Ch. 7 Subch. A (relating to judicial review of Commonwealth agency action) and address any violation through means appropriate to the nature and extent of the violation, which may include cease-and-desist orders, injunctive relief, restitution, suspension or revocation of certificates of authority or licenses, civil penalties and reimbursement of costs and reasonable attorney fees incurred by the aggrieved individual in bringing the complaint, or any combination of these; or

(2) file a civil action against the insurer in a court of original jurisdiction, which, upon proof of the act's violation by a preponderance of the evidence, shall award appropriate relief, including, but not limited to, temporary, preliminary or permanent injunctive relief, compensatory and punitive damages, as well as the costs of suit and reasonable attorney fees for the aggrieved individual's attorneys and expert witnesses. The aggrieved individual may elect, at any time prior to the rendering of final judgment, to recover in lieu of actual damages an award of statutory damages in the amount of $5,000 for each violation.

(b) Civil action.--

(1) If an aggrieved individual elects to file a complaint with the commissioner pursuant to subsection

(a)(1), that individual's right of action in a court of original jurisdiction shall not be foreclosed.

(2) If the commissioner has not secured a resolution of the complaint acceptable to the complainant within 180 days after the filing of the complaint, the complainant may file a civil action pursuant to subsection (a)(2). Upon the filing of a civil action, all proceedings before the commissioner shall terminate.

Section 7. Notice of change.

The enactment of this act shall be treated as a material notification of a change in the terms of a health insurance policy.

Section 8. Severability.

The provisions of this act are severable. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this act which can be given effect without the invalid provision or application.

Section 9. Effective date.

This act shall take effect in 60 days.