The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1414
INTRODUCER:	Senator Wise
SUBJECT:	Health Insurance
DATE:	March 11, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Stovall	HR	**Pre-meeting**
2.			BI	
3.			BC	
4.				
5.				
6.				

I. Summary:

The bill creates three new sections of statute within the Insurance Code designed to prevent a health insurance policy under which coverage is purchased with any state or federal funds through an exchange created under the federal Patient Protection and Affordable Care Act (PPACA) from providing coverage for an abortion unless the pregnancy is the result of an act of rape or incest or a physician certifies in writing that an abortion is necessary to save the life of the mother. The bill deems coverage to be purchased with state or federal funds if any tax credit or cost-sharing credit is applied to the policy. The bill provides that policies are allowed to provide separate coverage for an abortion if that separate coverage is not purchased with any state or federal funds. The bill defines "state" to mean the state of Florida or any political subdivision of the state.

This bill creates the following sections of the Florida Statutes: 627.64995, 627.66995, and 641.31099.

The bill substantially amends the following section of the Florida Statutes: 627.6515.

II. Present Situation:

The Federal Patient Protection and Affordable Care Act

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. The PPACA is a broad-based, national approach to reform various aspects of health insurance coverage, including the requirement for most U.S. citizens and legal residents to have health insurance by January 1, 2014. Under PPACA, those without coverage

pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5 percent of household income.

The PPACA contains a number of measures that attempt to make coverage more affordable and accessible. The PPACA allows states to create "exchanges" where individuals can purchase insurance and separate exchanges for small employers to purchase insurance, effective January 1, 2014. The PPACA allows for premium and cost-sharing subsidies to make exchange coverage more affordable. Details include:

- Individual coverage will be available through an "American Health Benefit Exchange."
- Small businesses with up to 100 employees can purchase coverage through a "Small Business Health Options Program" (SHOP) exchange. (Businesses with more than 100 employees can purchase coverage in a SHOP exchange beginning in 2017.)
- Plans in exchanges will be required to offer benefits that meet a minimum set of standards. Insurers will offer four levels of coverage that vary based on premiums, out-of-pocket costs, and benefits beyond the minimum required, plus a catastrophic coverage plan.
- Premium subsidies will be provided to families with incomes between 100-400 percent of the poverty level ($29,327 to $88,200 for a family of four in 2009) to help them purchase insurance through the exchanges. These subsidies will be offered on a sliding scale basis and will limit the cost of the premium to between 2 percent of income for those up to 133 percent of the poverty level and 9.5 percent of income for those between 300-400 percent of the poverty level.
- Cost-sharing subsidies will also be available to people with incomes between 100-400 percent of the poverty level to limit out-of-pocket spending.

Abortion Coverage Under PPACA Exchanges

The PPACA contains specific provisions permitting states to prohibit plans participating in an exchange from providing coverage for abortions.[1] The PPACA requires exchange plans that choose to offer coverage for abortions beyond coverage for which federal funds are permitted (to save the life of the woman and in cases of rape or incest), in states that allow such coverage, to create funding accounts for segregating premium payments for coverage of abortion services from premium payments for coverage for all other services. This is designed to ensure that no federal premium or cost-sharing subsidies are used to pay for the abortion coverage. Plans must also estimate the actuarial value of covering abortions by taking into account the cost of the abortion benefit (valued at no less than $1 per enrollee per month) and cannot take into account any savings that might be reaped as a result of abortions. The PPACA prohibits exchange plans from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.

Abortion in Florida Law

Under Florida law the term "abortion" means the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.[2] "Viability" means that

[1] 42 U.S.C. s. 18023
[2] Section 390.011, F.S.

stage of fetal development when the life of the unborn child may, with a reasonable degree of medical probability, be continued indefinitely outside the womb.[3] Induced abortion can be elective (performed for nonmedical indications) or therapeutic (performed for medical indications). Abortion can be performed by surgical or medical means (medicines that induce a miscarriage).[4] An abortion in Florida must be performed by a physician licensed to practice medicine or osteopathic medicine who is licensed under ch. 458, F.S., ch. 459, F.S., or a physician practicing medicine or osteopathic medicine in the employment of the United States.[5] No person who is a member of, or associated with, the staff of a hospital, or any employee of a hospital or physician in which, or by whom, the termination of a pregnancy has been authorized or performed, who states an objection to the procedure on moral or religious grounds is required to participate in the procedure. The refusal to participate may not form the basis for any disciplinary or other recriminatory action.[6]

The Hyde Amendment

The Hyde Amendment is the common name for a provision in the annual federal appropriations act for the U.S. Departments of Labor, Health and Human Services (HHS), and Education, which prevents Medicaid and any other programs under these departments from funding abortions, except in limited cases. The amendment is named after Rep. Henry J. Hyde (R-IL) who, as a freshman legislator, first offered the amendment.

The Hyde Amendment is not perpetually effective. By the nature of appropriations acts, which expire with each federal fiscal year unless extended temporarily, the provisions of the Hyde language must be reenacted with each annual federal budget in order to remain in effect.

The Hyde Amendment has been enacted into law in various forms since 1976, during both Democratic and Republican administrations. In 1980, the U.S. Supreme Court affirmed the constitutionality of the Hyde Amendment in *Harris v. McRae*.[7] In *Harris*, the Court determined that funding restrictions created by the Hyde Amendment did not violate the U.S. Constitution's Fifth Amendment, and therefore, did not controvene the liberty or equal protection guarantees of the Due Process Clause of the Fifth Amendment. The court opined that although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those obstacles that are not created by the government (in this case indigence). The court further opined that although Congress has opted to subsidize medically necessary services generally, but not certain medically necessary abortions, the Hyde Amendment leaves an indigent woman with at least the same range of choice in deciding whether to obtain a medically necessary abortion as she would have had if Congress had chosen to subsidize no health care costs at all.[8]

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[3] Section 390.0111, F.S.
[4] Suzanne R. Trupin, M.D., *Elective Abortion*, December 21, 2010, available at: http://www.emedicine.com/med/TOPIC3312.HTM (Last visited on March 11, 2011).
[5] Section 390.0111(2), F.S.
[6] Section 390.0111(8), F.S.
[7] 448 U.S. 297 (1980). *See also Rust v. Sullivani*, 500 U.S. 173 (1991) and *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989), upholding *Harris v. McRae*.
[8] *Harris*, 448 U.S. at 316-317.

In Florida, based on the Hyde Amendment, Medicaid reimburses for abortions for one of the following reasons:

- The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed;
- When the pregnancy is the result of rape (sexual battery) as defined in s. 794.011, F.S.; or
- When the pregnancy is the result of incest as defined in s. 826.04, F.S.[9]

In such cases, the state Medicaid program requires an Abortion Certification Form to be completed and signed by the physician who performed the abortion. The form must be submitted with the facility claim, the physician's claim, and the anesthesiologist's claim. The physician must record the reason for the abortion in the physician's medical records for the recipient.[10]

III. Effect of Proposed Changes:

Sections 1, 2, and 3 create s. 627.64995, F.S., s. 627.66995, F.S., and s. 641.31099, F.S., respectively, relating to individual health insurance policies, group health insurance policies, and health maintenance organization contracts, respectively, to prevent coverage issued under those sections that is purchased with any state or federal funds through an exchange created under the PPACA from providing coverage for an abortion unless the pregnancy is the result of an act of rape or incest or a physician certifies in writing that an abortion is necessary to save the life of the mother. The bill deems coverage to be purchased with state or federal funds if any tax credit or cost-sharing credit is applied to the policy.

The bill provides that such policies are allowed to provide separate coverage for an abortion if that separate coverage is not purchased with any state or federal funds.

The bill defines "state" to mean the state of Florida or any political subdivision of the state.

Section 4 amends s. 627.6515, F.S., relating to out-of-state health insurance policies, to provide that part VII of ch. 627, F.S., relating to group, blanket, and franchise health insurance policies, does not apply to a group health insurance policy issued or delivered outside of Florida under which a Florida resident is provided coverage if the policy provides benefits specified in a list of multiple sections of statute. The bill adds s. 627.66995 to that list, indicating that if an out-of-state group policy provides separate coverage for abortion that is not purchased with any state or federal funds, then part VII of ch. 627, F.S., would not apply to that policy.

Section 5 provides an effective date for the bill of July 1, 2011.

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[9] Agency for Health Care Administration, *Florida Medicaid: Ambulatory Surgery Center Services Coverage and Limitations Handbook*, January 2005, available at: http://www.baccinc.org/medi/CD_April_2005/Provider_Handbooks/Medicaid_Coverage_and_Limitations_Handbooks/Ambulatory_Surgical_Center_Updated_January_2005.pdf (Last visited on March 11, 2011).

[10] *Id.*

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of the bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The Office of Insurance Regulation (OIR) advises that if health plans offer coverage through a PPACA exchange and those plans operate a separate accounting for coverage paid for with any amount of state or federal funds versus coverage not paid for with any state or federal funds, as indicated in the bill, the health plans could incur some measure of administrative cost resulting from this legislation.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

The OIR notes that in section 1 of the bill, the language created in s. 627.64995, F.S., relating to individual health insurance policies, includes "or group health insurance policy" and advises that "or group health insurance policy" should be deleted. Section 627.601(2), F.S., specifically excludes application of provisions within part VI of ch. 627 to group policies within part VII.

VII. Related Issues:

If section 2 of the bill is intended to apply to small group policies under s. 627.6699, F.S., the bill should be amended to specifically apply to that section of statute. The provisions of s. 627.6699(16), F.S., could prevent the provisions of s. 627.66995, F.S., which is created by the bill, from applying to small group policies under s. 627.6699, F.S.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.