Office of Senate Floor Analyses
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THIRD READING

Bill No: SB 245
Author: Gonzalez (D), et al.
Amended: 4/12/21
Vote: 21

SENATE HEALTH COMMITTEE: 8-2, 4/7/21
AYES: Pan, Eggman, Gonzalez, Leyva, Limón, Roth, Rubio, Wiener
NOES: Melendez, Grove
NO VOTE RECORDED: Hurtado

SENATE APPROPRIATIONS COMMITTEE: 5-2, 5/20/21
AYES: Portantino, Bradford, Kamlager, Laird, Wieckowski
NOES: Bates, Jones

SUBJECT: Health care coverage: abortion services: cost sharing

SOURCE: ACCESS Reproductive Justice
Black Women for Wellness Action Project
NARAL Pro-Choice California
National Health Law Program
Planned Parenthood Affiliates of California

DIGEST: This bill prohibits cost-sharing, restrictions, delays, prior authorization and annual or lifetime limits on all abortion services, including follow-up services, to an enrollee or insured; and requires benefits to be the same for enrollees or insureds covered spouse and covered nonspouse dependents.

ANALYSIS:

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act); California Department of Insurance (CDI) to regulate health and other insurance; and, the Department of Health Care Services (DHCS) to

administer the Medi-Cal program. [HSC §1340, et seq., INS §106, et seq., and WIC §14000, et seq.]

2) Requires every California health plan and insurer to comply with requirements of the Affordable Care Act (ACA) that prohibits plans and issuers from imposing lifetime or annual limits on the dollar value of essential health benefits (EHBs), and any issued rules, in addition to any state laws or regulations that do not prevent the application of those requirements. Excludes Medi-Cal managed care and other state programs to the extent consistent with the ACA. [HSC §1367.001 and INS §10112.1]

3) Establishes the Reproductive Privacy Act, which prohibits the state from denying or interfering with a woman's right to choose or obtain an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the woman. [HSC §123460, et seq.]

4) Makes the performance of an abortion unauthorized if either of the following is true:

   a) The person performing the abortion is not a health care provider authorized to perform an abortion, as specified; or,

   b) The abortion is performed on a viable fetus, and in the good faith medical judgment of the physician, the fetus was viable, and, continuation of the pregnancy posed no risk to life or health of the pregnant woman. [HSC §123468]

This bill:

1) Prohibits a health plan, except for a specialized health plan contract, and group or individual policy of disability insurance, except a specialized health insurance policy, that is issued, amended, renewed, or delivered on or after January 1, 2022, from imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on coverage for all abortion and abortion related services, including pre abortion and follow-up services including, but not limited to, management of side effects and counseling.

2) Prohibits, except as otherwise authorized, a health plan or insurer from imposing utilization management or utilization review, including prior authorization and annual or lifetime limits consistent with existing law, on the coverage for abortion services.

3) Subjects Medi-Cal managed care plans that contract with DHCS, providers, independent practice associations, preferred provider groups, and all delegated entities that provide physician services, utilization management or utilization review, to this bill.

4) States that cost sharing limits for high deductible health plans, as defined, apply once the deductible has been satisfied for the benefit year and, this bill does not deny or restrict in any way DMHC's or CDI's authority to ensure plan compliance when a health plan or insurer provides coverage for abortion services.

5) States that this bill does not require an individual or group health plan contract or disability insurance policy to cover an experimental or investigational treatment.

6) Defines "abortion" as any medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth.

Background

Author's statement. According to the author, while California is a leader when it comes to protecting abortion rights, far too many Californians continue to experience barriers to care. California is one of six states that require health insurance plans to cover the cost of abortion, but many enrollees must still make hefty co-payments or cost-sharing to receive care. Deductibles and copays can range from $40 to thousands of dollars, which are cost-prohibitive for low- and middle-income families. On average, abortion care can cost a patient $500 at ten weeks gestation, with the median cost of an abortion rising to $1,195 at 20 weeks gestation. These high costs create a significant barrier to care and disproportionately affect people of color, LGTBQ individuals, people with disabilities, young people, and people who are low income. This bill, the Abortion Accessibility Act, will ensure no Californian is denied their right to abortion services due to the cost. This bill will require all state-licensed commercial health plans and insurers to cover abortion care without cost-sharing. By removing cost barriers to abortion care, California takes a critical step forward to ensuring that equitable, timely access to healthcare services is attainable to all Californians regardless of an individual's bank account size.

California Health Benefits Review Program (CHBRP) analysis. CHBRP considered induced abortion a medical treatment that causes the termination of a pregnancy performed using medication or procedure (surgical). Associated services refers to pre abortion evaluation and follow-up care, including counseling

services. Emergency contraception, selective reduction, spontaneous miscarriage, ectopic pregnancies, and stillbirths are not included in induced abortion.

Coverage impacts and enrollees covered. CHBRP assumes most women who, at baseline forego using their private insurance to cover abortions for reasons other than cost (privacy or lack of knowledge) would continue to do so. At baseline, CHBRP estimates there are 23,492 enrollees who have induced abortions and use associated services in DMHC-regulated plans and CDI- regulated policies. Of those 13,840 enrollees had no cost sharing and 9,652 have cost sharing for abortion services. With respect to associated services, 4,429 have no cost sharing and 5,366 have cost sharing. Postmandate 23,589 enrollees and insured are projected to have abortions, and 9,849 associated services, without cost sharing.

Medical effectiveness. CHBRP found insufficient evidence that utilization management policies affect abortion outcomes, limited evidence that cost-sharing policies reduce access to, and use of, abortion services and insufficient evidence that cost sharing for abortion services affects maternal health outcomes. CHBRP found limited evidence to suggest that unintended pregnancy leads to a decrease in prenatal care and breastfeeding and an increase in postpartum depression and low birth weight or preterm births. CHBRP found insufficient evidence that unintended pregnancies impact maternal health outcomes, limited evidence that not obtaining a chosen abortion may have socioeconomic consequences for the children and that there is no impact on child health outcomes. CHBRP also found inconclusive evidence of the impact on child development of children born to women who were denied an abortion.

Public health. Using a logic model, CHBRP determined elimination of cost sharing and utilization management policies, as proposed under this bill, would reduce some barriers that cost and delays can present in obtaining an abortion and consequently would increase access to timely abortion services and an increase in abortions completed when chosen. The average out-of-pocket cost for any abortion services is $543, which has been shown to be a financial barrier. This bill may provide a financial benefit for the approximately 9,650 commercially-insured women who had cost sharing for covered abortions at baseline. These estimates are supported by limited evidence.

EHBs. This bill does not require coverage for a new state benefit mandate. It modifies cost sharing terms and conditions of an already covered benefit. Therefore, this bill appears not to exceed the definition of EHB.

DMHC. The Knox Keene Act requires the provision of basic health care services and the California Constitution prohibits health plans from discriminating against

women who choose to terminate a pregnancy. Thus, all health plans must treat maternity services and legal abortion neutrally. Exclusions and limitations are also incompatible with both the California Reproductive Privacy Act and multiple California judicial decisions that have unambiguously established under the California Constitution that every pregnant woman has the fundamental right to choose to either bear a child or to have a legal abortion. A health plan is not required to cover abortions that would be unlawful under existing law.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee:

DMHC: This bill's costs would be incurred by different units within the DMHC as The bill's costs would be incurred by different units within the DMHC as described below. All costs associated with this bill would be incurred by the Managed Care Fund (MCF) and covered through fees assessed on health plans. The DMHC estimates the total cost of this bill to be approximately $127,000 MCF in FY 2021-22, $46,000 MCF in FY 2022-23, $44,000 MCF in FY 2023-24 and annually thereafter:

- The DMHC's Office of Legal Services (OLS) anticipates short-term workload to conduct legal research and issue two legal memoranda to clarify the requirements set forth in SB 245. The DMHC estimates costs for OLS to be approximately $61,000 FY 2021-22 only.

- The DMHC's Office of Plan Licensing (OPL) anticipates additional workload to review health plan documents, including Evidence of Coverage and disclosure forms, for compliance with the requirements set forth in SB 245. The DMHC estimates costs for OPL to be approximately $66,000 and in FY 2021-22, $46,000 and 0.2 PY in FY 2022-23, $44,000 and 0.2 PY in FY 2023-24 and annually thereafter.

Department of Health Care Services did not have information to share when this analysis was prepared.

The state costs of premium increases of the $4 million increase in premiums is unknown at this time.

CHBRP reviewed this bill. Fiscal impact findings are included below:

- *Utilization*. CHBRP estimates postmandate a 1% increase in utilization would occur resulting in an additional 97 women obtaining abortions with zero cost sharing.

- *Medi-Cal.* Medi-Cal already covers abortions without cost sharing. California is one of sixteen states that use state funds to cover abortion services and follow-up services for beneficiaries. The Medi-Cal program covers abortions as physician service without cost sharing for all enrollees. Medi-Cal managed care plans, providers, independent practice associations, preferred provider groups, and all delegated entities that provide physician services are prohibited from requiring medical justification and/or prior authorization for outpatient abortion services (DHCS All Plan Letter 15-020). Inpatient hospitalizations for surgical abortions do require prior authorization, as other medical procedures requiring hospitalization. However, hospitalizations due to induced abortions are rare, so CHBRP assumes this bill will have no effect on Medi-Cal managed care beneficiaries.

- *Impact on expenditures*. CHBRP estimates that this bill would result in a $4,026,000 increase in total health insurance premiums by employers and enrollees (with the greatest increase in premiums for commercial individual plans of $1,361,000. The premium increases are offset by $5,527,000 decrease in enrollee cost sharing for those enrollees using induced abortions and services. As such, CHBRP estimates a decrease of total net annual expenditures of $1,501,000. CHBRP indicates average premium increases ranging from $.003 per member per month (pmpm) (DMHC-regulated large group, enrollee share) up to $.06 pmpm (CDI-regulated individual market insured), depending upon market segment. The per-unit cost of continuing a pregnancy averages $25,574. The discontinuation of these 97 pregnancies postmandate leads to an estimated cost offset of $2,455,000. For California Public Employees' Retirement System HMO enrollees, there is an estimated increase of $128,000 in premiums due to the elimination of enrollee cost sharing.

SUPPORT: (Verified 5/19/21)

ACCESS Reproductive Justice (co-source)
Black Women for Wellness Action Project (co-source)
NARAL Pro-Choice California (co-source)
National Health Law Program (co-source)
Planned Parenthood Affiliates of California (co-source)
American Academy of Pediatrics, California
American College of Obstetricians and Gynecologists
Association of American University Women-California
Business & Professional Women of Nevada County
California Academy of Family Physicians
California Latinas for Reproductive Justice

California Pan-Ethnic Health Network
California Women's Law Center
CaliforniaHealth+ Advocates
Citizens for Choice
Empowering Pacific Islander Communities
Essential Access Health
Health Access California
If/When/How: Lawyering for Reproductive Justice
Los Angeles County Democratic Party
National Association of Social Workers, California Chapter
Religious Coalition for Reproductive Choice
Santa Barbara Women's Political Action Committee
The Women's Foundation California
Western Center on Law & Poverty, Inc.
One Individual

OPPOSITION: (Verified 5/19/21)

America's Health Insurance Plans
Association of California Life and Health Insurance Companies
California Association of Health Plans
California Catholic Conference
California Family Council
Californians for Life
Capitol Resource Institute
Real Impact
Right to Life League of Southern California
14 Individuals

ARGUMENTS IN SUPPORT: ACCESS Reproductive Justice, Black Women for Wellness Action Project, NARAL Pro-Choice California, National Health Law Program, and Planned Parenthood Affiliates of California cosponsor this bill and write that removing cost-sharing for abortion, ensures that no one in California is unable to access care because of the cost of the service. People enrolled in commercial insurance plans pay deductibles and copays that range from forty dollars to thousands of dollars; costs that are often prohibitive for low- and middle-income families. The rising cost of an abortion can cause a harmful feedback loop: the longer it takes someone to raise funds for their abortion, the higher the cost becomes because of gestation, which in turn means they must raise more funds. This not only means that someone isn't able to get timely access to care; it can also prevent them from getting an abortion in California, or at all. These high costs

create a significant barrier to care and disproportionately affect people of color, transgender and non-binary individuals, people with disabilities, young people and people experiencing poverty, perpetuating systemic health care disparities. The University of California, San Francisco conducted a five-year longitudinal study of roughly 1,000 women seeking abortion care at 30 facilities across the United States and found that for more than half of women who received an abortion, their out-of-pocket costs were equivalent to more than one-third of their monthly personal income. Everyone deserves the right to decide if, when, and how they grow their family regardless of income, insurance type, and without stigma or shame. By removing cost barriers to abortion, California takes a step forward to ensure that equitable, timely access to healthcare services is attainable regardless of an individual's income, insurance type, status, race, zip code, or bank account.

ARGUMENTS IN OPPOSITION: Californians for Life write that at least one human being is killed in every abortion and millions of women have been hurt by abortion. Women need support not free abortions to kill their children.

America's Health Insurance Plans, the Association of California Life and Health Insurance Companies, and the California Association of Health Plans, writing in opposition to a number of mandate bills, state that California has been a national leader in maintaining a stable market despite rising costs and uncertainty at the federal level over the individual and employer market. The COVID-19 pandemic has forced us all to re-evaluate our priorities this year, focusing on the critical issues necessary to address this pandemic. Now is not the time to inhibit competition with proscriptive mandates that reduce choice and increase costs. In the face of this continued uncertainty and efforts to fragment the market and promote less comprehensive coverage, California needs to protect the coverage gains we've made and stay focused on the stability and long-term affordability of our health care system. Benefit mandates impose a one-size-fits-all approach to medical care and benefit design driven by the legislature, rather than consumer choice. These bills will lead to higher premiums, harming affordability and access for small businesses and individual market consumers. State mandates increase costs of coverage – especially for families who buy coverage without subsidies, small business owners who cannot or do not wish to self-insure, and California taxpayers who foot the bill for the state's share of those mandates.

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
5/22/21 14:59:29

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