SENATE THIRD READING
SB 245 (Gonzalez)
As Amended April 12, 2021
Majority vote

SUMMARY

Prohibits a health care service plan (health plan) or an individual or group policy, as specified, 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. Prohibits a health plan or a health insurer from imposing utilization management or utilization review on the coverage for abortion services. Applies these requirements to Medi-Cal managed care (MCMC) plans, providers, independent practice associations, preferred provider groups, and all delegated entities that provide physician services, utilization management, or utilization review.

COMMENTS

According to California Health Benefit Review Program (CHBRP), under the Reproductive Privacy Act, California law 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 medically necessary. The state defines viability as the point in a pregnancy when, in the good faith medical judgment of a physician, there is a reasonable likelihood that a fetus will survive outside the uterus without "extraordinary medical measures." Abortion is considered a basic health care service in California and, therefore, is required to be covered by commercial health insurance plans and policies and CalPERS. Medically necessary follow-up services to abortions that constitute basic health care services must also be covered. However, the state does not mandate which types of abortion methods (i.e., procedural or medication) must be covered, nor does it mandate cost-sharing requirements specific to these services. California's Medi-Cal program is one of 16 state Medicaid programs that use their own funds to cover abortion services and follow-up services for beneficiaries. The Medi-Cal program covers abortions as a physician service without cost sharing for all enrollees. California law prohibits family planning grants distributed by Department of Health Care Services (DHCS) from funding abortions or associated services, including post abortion examinations.

Under federal law, since 1976, Congress has included a provision, the Hyde Amendment, in the annual appropriations legislation for the Departments of Labor, Health and Human Services, and Education prohibiting the use of federal funds for most abortions. The only exceptions to this prohibition are in cases of rape, incest, or if a woman suffers from a life-threatening physical injury or illness that would place her in danger of death unless an abortion is performed. Medicaid is a jointly funded program by the federal and state governments. States may choose to pay for abortion services for additional circumstances; however, they must use nonfederal funds to pay for the service. Sixteen states currently have policies that allow for Medicaid funds to be used to pay for abortions that exceed Hyde limitations, including Alaska, California, Connecticut, Hawaii, Illinois, Oregon, Maine, Maryland, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, New York, Washington, and Vermont.

1) *CHBRP analysis.* AB 1996 (Thomson), Chapter 795, Statutes of 2002, requests the University of California to assess legislation proposing a mandated benefit or service and

prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on essential health benefits, and legislation that impacts health insurance benefit designs, cost sharing, premiums, and other health insurance topics. CHBRP states the following in its analysis of this bill:

a) *Enrollees covered.* At baseline, CHBRP estimates there are 23,492 users of any abortion services, including medication and procedural abortions and associated services, enrolled in plans regulated by Department of Managed Health Care (DMHC) and policies regulated by California Department of Insurance (CDI). Of this population, 9,652 users of any abortion services have cost sharing. Postmandate, 100% of users of abortion services with cost sharing at baseline will have zero cost sharing. MCMC plans are prohibited from requiring medical justification and/or prior authorization for outpatient abortion services. Based on a CHBRP survey of California health insurance providers, state-regulated health plans and policies do not require utilization management, including prior authorization, for abortion services, except for one health plan that stated prior authorization and medical necessity review is required for inpatient admissions. Medi-Cal policy also requires prior authorization for inpatient hospitalizations for procedural abortions.

b) *Impact on expenditures.* Average out-of-pocket costs for enrollees who use any abortion services and have cost sharing is $543. The average cost share is $306 for a medication abortion, $887 for a procedural abortion, and $182 for associated services. These do not reflect average total costs per enrollee for services, which would depend on the amount and type of services used. Postmandate, enrollees with coverage with cost sharing for abortion services at baseline would have $0 cost sharing for abortion services, including associated medical care. This bill would decrease total net annual expenditures by $1,501,000, or 0.0011%, for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to a $5,527,000 decrease in enrollee cost sharing for covered benefits adjusted by a $4,026,000 increase in total health insurance premiums paid by employers and enrollees. Total premiums for private employers purchasing group health insurance would increase by $1,808,000, or 0.0033%. Total premiums for purchasers of individual market health insurance would increase by $1,361,000, or 0.0086%. Changes in premiums as a result of this bill would vary by market segment. The greatest change in premiums as a result of this bill is for DMHC-regulated individual market plans (0.0085% increase) and for CDI-regulated individual market policies (0.0104% increase). Among publicly funded DMHC-regulated health plans, there is no impact on Medi-Cal premiums because no enrollees have cost sharing for induced abortion services or related associated care. Among CalPERS health maintenance organization (HMO) plans, there is an estimated increase of $128,000, or 0.0022%, in premiums. The decreases in enrollee expenditures for covered benefits in commercial plans range from $0.0242 per member per month (PMPM) among enrollees in DMHC-regulated large-group plans to $0.0594 PMPM among enrollees in CDI-regulated individual policies. Among publicly funded plans, there is no impact for Medi-Cal enrollees; however, CalPERS enrollees will have a decrease in enrollee expenditures of $0.0249 PMPM. Medi-Cal covers abortions as a physician service without cost sharing. Medi-Cal policy prohibits requiring medical justification and/or prior authorization for outpatient abortion services. Inpatient hospitalizations for procedural abortions do require prior authorization; however, this

mandate follows the same criteria as any other medical procedure requiring hospitalization. As such, no impact on this population by this bill is projected. For CalPERS HMO enrollees, there is an estimated increase of $128,000, or 0.0022%, in premiums due to the elimination of enrollee cost sharing under this bill.

c) *Medical effectiveness.* CHBRP developed a logic model to determine the potential impacts of cost sharing policies on utilization of abortions services and their related health outcomes and is based on the idea that the elimination of cost sharing and utilization management policies, as proposed under this bill, would reduce the barriers that cost and delays related to cost and utilization management can present in obtaining an abortion. As such, this bill would lead to increased access to timely abortion services, and therefore an increase in abortions completed when chosen. Consequently, this bill would decrease unintended pregnancies, which are associated with poor pregnancy and maternal health outcomes.

e) *Public health.* CHBRP projects that the removal of cost sharing for abortion services, as proposed under this bill, would enable an additional 97 women, for whom the baseline cost-sharing requirements would have otherwise prevented them from accessing these services, to obtain an abortion. For those women, this bill may reduce the negative health outcomes associated with being unable to access an abortion. CHBRP estimates the average out-of-pocket cost for any abortion service is $543, which has been shown to be a financial barrier. Therefore, this bill may also 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 that cost-sharing policies reduce access to, and use of, abortion services. CHBRP did not identify any studies that assessed utilization management among those with insurance coverage for abortion; therefore, there is insufficient evidence that utilization management policies affect abortion outcomes. Although there is evidence of disparities in the United States related to racial/ethnic disparities in the rates of abortions, CHBRP found insufficient evidence of reduction in racial/ethnic disparities due to eliminating cost sharing and utilization management among women with commercial insurance. CHBRP notes that the absence of evidence is not "evidence of no effect." It is possible that an impact, desirable or undesirable, could result, but current evidence is insufficient to inform an estimate. CHBRP also found insufficient evidence of reduction in income-related disparities due to eliminating cost sharing among women with commercial insurance. Despite the lack of evidence that eliminating cost sharing results in increased utilization of abortions and associated services, this bill may have an impact for a subset of women with commercial insurance who are unable to pay the full or unmet deductibles and copayments or coinsurance for abortion services. CHBRP found insufficient evidence of reduction in age related disparities due to eliminating cost sharing among women with commercial insurance. However, this bill may have an impact for adolescents who are willing to use their parent's commercial insurance coverage or have their own commercial insurance and who are unable to pay the full or unmet deductibles and copayments or coinsurance for abortion services.

f) *Other states.* According to CHBRP, three states have passed laws that prohibit commercial health insurance plans from imposing cost sharing for abortion coverage, as of February 2021. Illinois prohibits private health insurance plans from imposing any deductibles, coinsurance, waiting periods, or other cost-sharing limitations that are

greater than what is required for other pregnancy-related benefits covered by the policy. Oregon requires private health insurance plans to cover all reproductive health services, including abortion services, with no cost sharing. New York prohibits copayments, coinsurance, or annual deductibles on medically necessary in-network abortion services, with limited exceptions for high deductible health plans. Massachusetts and New Jersey have recently introduced legislation similar to this bill.

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. These high costs create a significant barrier to care and disproportionately affect people of color, LGTBQ individuals, people with disabilities, young people, and people with low income. According to the author, 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. The author concludes that 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.

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, cosponsors of this bill, write that 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. The cosponsors state that 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
The California Family Council writes that this bill requires millions of pro-life Californians to violate their consciences and fund abortion through their health insurance. This is deeply offensive to people of faith.

FISCAL COMMENTS

According to the Assembly Appropriations Committee:

1) According to CHBRP, this bill results in the following costs:

    a) Overall estimated increase in premium costs to CalPERS of $128,000 (state General Fund, special funds and federal funds, and local funds), based on the elimination of employee cost-sharing.

b) Increased employer-funded premium costs in the private insurance market of approximately $1.8 million.

c) Reduced out-of-pocket expenses among insured individuals of $5.5 million.

2) Potential for significant increased costs to the DHCS to pay increased capitation rates to MCMC plans, associated with provisions that would broadly prohibit utilization management and utilization review activities for abortion services. These costs are uncertain but could be in the millions of dollars if interpreted broadly to include, for example, a prohibition on utilization review of abortion-related non-emergency inpatient hospitalization services and a range of other services (General Fund).

3) Costs to the DMHC of approximately $130,000 in fiscal year 2021-22 and $45,000 annually thereafter (Managed Care Fund). This includes workload to review health plan documents for compliance and one-time costs for legal research and preparation of legal memoranda.

4) Costs of $18,000 one-time to CDI (Insurance Fund) to verify plan and policy compliance, and minor and absorbable costs ongoing.

VOTES

SENATE FLOOR: 31-8-1
YES: Allen, Archuleta, Atkins, Becker, Bradford, Caballero, Cortese, Dodd, Durazo, Eggman, Glazer, Gonzalez, Hertzberg, Hueso, Hurtado, Kamlager, Laird, Leyva, Limón, McGuire, Min, Newman, Pan, Portantino, Roth, Rubio, Skinner, Stern, Umberg, Wieckowski, Wiener
NO: Bates, Borgeas, Dahle, Grove, Jones, Nielsen, Ochoa Bogh, Wilk
ABS, ABST OR NV: Melendez

ASM HEALTH: 11-3-1
YES: Wood, Aguiar-Curry, Eduardo Garcia, Burke, Carrillo, Maienschein, McCarty, Nazarian, Luz Rivas, Rodriguez, Santiago
NO: Bigelow, Flora, Waldron
ABS, ABST OR NV: Mayes

ASM APPROPRIATIONS: 12-3-1
YES: Holden, Bryan, Calderon, Luz Rivas, Gabriel, McCarty, Levine, Quirk, Robert Rivas, Akilah Weber, Stone, Mullin
NO: Bigelow, Davies, Fong
ABS, ABST OR NV: Megan Dahle

UPDATED

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