Office of Senate Floor Analyses
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THIRD READING

Bill No: SB 523
Author: Leyva (D), et al.
Amended: 5/3/21
Vote: 21

SENATE LABOR, PUB. EMP. & RET. COMMITTEE: 4-0, 4/5/21
AYES: Cortese, Durazo, Laird, Newman
NO VOTE RECORDED: Ochoa Bogh

SENATE HEALTH COMMITTEE: 8-2, 4/28/21
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: contraceptives

SOURCE: Essential Access Health
NARAL Pro-Choice California
National Health Law Program

DIGEST: This bill establishes the Contraceptive Equity Act of 2021 (Act), which ensures coverage for federal Food and Drug Administration-approved contraceptive drugs, devices, and products without cost sharing and medical management applicable to all insureds and enrollees, as specified, and requires employee health benefit plan contracts provided by the California Public Employees Retirement System (CalPERS), the University of California (UC), the California State University (CSU), and plans directly operated by a bona fide public or private institution of higher learning to comply with the Act. Establishes specified limitations on employers with respect to an employee's reproductive decision making.

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) Establishes as California's essential health benefits (EHBs) benchmark the Kaiser Small Group Health Maintenance Organization, existing California mandates (including medically necessary basic health care services), and ten Affordable Care Act (ACA) mandated benefits. Requires non-grandfathered individual and small group health plan contracts and insurance policies to cover these EHBs. [HSC §1367.005 and INS §10112.27]

3) Requires a health plan contract, except for a specialized health plan contract, and a disability insurance policy, that provides outpatient prescription drug benefits to provide coverage for all FDA-approved contraceptive drugs, devices, and other products for women, including all FDA-approved contraceptive drugs, devices, and products available over the counter (OTC), as prescribed by the enrollee's provider, voluntary sterilization, patient education and counseling on contraception, and follow up services, as described. [HSC §1367.25 and §10123.196]

4) Permits a religious employer to request a health plan contract or disability insurance policy without coverage for contraceptive methods that are contrary to the religious employer's religious tenets, and requires a contract or policy to be provided without contraceptive methods. Requires an employer that invokes the exemption to provide written notice to any prospective employee once an offer of employment has been made, and prior to that person commencing that employment. [HSC §1367.25 and §10123.196]

This bill:

1) Prohibits, commencing January 1, 2022, the CalPERS board, UC, and the CSU from approving a health benefit plan contract for employees that does not comply with the contraceptive coverage requirements of existing law and this

bill.

2) Makes services and contraceptive coverage requirements under existing law and this bill applicable to all subscribers, policyholders, insureds and enrollees, and a plan, approved on or after January 1, 2023, that is otherwise exempt from the Knox-Keene Act, that is directly operated by a bona fide public or private institution of higher learning which directly provides health care service only to its students, faculty, staff, administration, and their respective dependents.

3) Prohibits a health plan and insurer from requiring a prescription to trigger coverage of OTC FDA-approved contraceptive drugs, devices, and products.

4) Requires a health plan and insurer to provide point-of-sale coverage for OTC FDA-approved contraceptive drugs, devices, and products at in-network pharmacies without cost-sharing or medical management restrictions.

5) Requires, if a therapeutically equivalent is not available or medically inadvisable, the plan or insurer to defer to the determination and judgment of the attending provider and provide coverage for the alternative prescribed contraceptive drug, device, product, or service without imposing any cost-sharing requirements. States that medical inadvisability may include considerations such as severity of side effects, differences in permanence or reversibility of contraceptives, and ability to adhere to the appropriate use of the drug or item, as determined by the attending provider.

6) Prohibits a health plan from infringing upon an enrollee's/insured's choice of contraceptive drug, device, or product, including prior authorization, step therapy, or other utilization control techniques, except as authorized in the law.

7) Defines provider, for purposes of furnishing family planning services, to include a pharmacist, as specified.

8) Prohibits a health plan or insurer that is required to cover a 12-month supply of FDA-approved, self-administered hormonal contraceptives dispensed or furnished by a provider or pharmacist, from requiring an enrollee or insured to make any formal request for such coverage other than a pharmacy claim.

9) Prohibits the exclusion from coverage for a religious employer from applying to a contraceptive drug, device, procedure, or other produce that is used for

purposes other than contraception.

10) States the changes made by this bill apply only to a health plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2022.

11) Prohibits an employer from failing or refusing to hire or discharge any individual or otherwise discriminate or take any retaliatory personnel action against any employee with respect to compensation, terms, conditions, or privileges of employment because of the employee's or their dependent's reproductive health decision making, including a decision to use or access a particular drug, device, or medical service.

12) Makes an employer, or any person acting on behalf of an employer, who takes any adverse employment action against an employee in violation 16) above liable to the aggrieved employee, who shall recover a penalty, as specified, and obtain any other appropriate relief to remedy the violation, including reinstatement, reimbursement of lost wages and interest thereon, and other compensation or equitable relief appropriate to the circumstances.

Comments

Author's statement. According to the author, this bill is the Contraceptive Equity Act of 2021 and seeks to expand and modernize birth control access in California, and ensure greater contraceptive equity statewide, regardless of an individual's gender or insurance coverage status.

California Health Benefits Review Program (CHBRP) analysis key findings include:

1) *Medical effectiveness.* Over the course of a year, sexually active women of child bearing age not using contraceptives have an 85% chance of becoming pregnant, with a 46% unintended pregnancy rate among women discontinuing previous contraceptive use. CHBRP found clear and convincing evidence that using any of the contraceptives impacted by this bill is more effective than not using any contraception in preventing unintended pregnancies. CHBRP also found there is clear and convincing evidence that condoms are effective at preventing transmission of STIs/HIV based on a systematic review of 14 studies. There is also clear and convincing evidence based on a systematic review of five randomized controlled trials (RCTs) that spermicide is not effective in stopping transmission of STIs/HIV. There is insufficient evidence

to determine how insurance coverage for contraceptives affected by this bill (i.e., nonprescription OTC contraceptives and vasectomy) impacts contraceptive utilization. There is insufficient evidence on the impact of utilization management policies on contraceptive utilization.

2) *Utilization*. Postmandate, an additional 252 enrollees would obtain vasectomies and related clinical services for a total of 14,455 enrollees, an increase of 1.77%

3) *Impact on expenditures*. According to the CHBRP's Cost and Coverage Model, there would be an estimated 12,293 averted unintended pregnancies in the first year postmandate, a reduction of 11.56% from baseline. These pregnancy outcomes at baseline result in an average of $13,951 per averted unintended pregnancy, accounting for labor and delivery charges, medical costs associated with stillbirths or miscarriages, and costs for abortion services. Given the postmandate induced coverage of vasectomies, CHBRP estimates a 5.64% reduction in tubal ligations, resulting in an estimated cost offset of $19,014 per unit for female sterilization procedures and related clinical services. Due to cost offsets from a reduction in unintended pregnancies and female sterilization procedures postmandate, CHBRP estimates that this bill would decrease total premiums by about $66,743,000 across DMHC- and CDI-regulated plans and policies. This bill would decrease total net annual expenditures by $182,077,000 (0.14%) for enrollees with plans regulated by the DMHC and policies regulated by the CDI. This is due to a $66,743,000 decrease in total health insurance premiums paid by employers and enrollees for newly covered benefits and a decrease of $8,202,000 in enrollee expenses for covered benefits and $107,133,000 in enrollee expenses for noncovered benefits.

4) *Public health*. In the first year postmandate, there would be a reduction in the number of unintended pregnancies overall (12,293 averted), as well as a reduction in negative health outcomes associated with unintended pregnancy. In addition, there are broad benefits of contraceptive use and the estimated additional 89,481 enrollees using nonprescription OTC contraceptives or vasectomy would benefit from these noncontraceptive health and family planning benefits. In the first year postmandate, to the extent that this bill reduces disparities that are due to coverage differences or ameliorates barriers due to out of pocket costs (but not due to preferences about specific contraceptive coverage). CHBRP estimates a reduction in disparities related to race/ethnicity, age, and social determinants of health in contraceptive use and unintended pregnancy; however, the magnitude is unknown.

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

According to the Senate Appropriations Committee:

- UC would total $895,000 annually across its three insurance plans (General Fund).

- CSU system indicates that the bill would result in unknown cost increases (General Fund) by potentially increasing employer contribution and/or employee premiums. This bill would not affect the CSU's student health centers, which already provide no-cost birth control options for students.

- The CalPERS indicates that all of its plans (HMOs and PPOs) would incur some cost for the elimination of member cost sharing (typically co-pays or deductibles) for contraception. As an example, in 2019, its members in PPO plans paid about $137,000 in member cost sharing for tubal ligation and vasectomy procedures. This member paid amount would be absorbed by the health plans under this bill. Its total cost increase to CalPERS has yet to be determined.

- The bill would result in one-time costs to CDI of $57,000 in 2021-22 and $64,000 in 2022-23 to review health insurance policies and adopt regulations (Insurance Fund).

- DMHC estimates the total cost of this bill to be $96,000 in 2021-22, $392,000 in 2022-23, and about $300,000 annually thereafter (Managed Care Fund).

- The Department of Industrial Relations (DIR) would incur costs related to investigations and enforcement of Labor Code violations. Ongoing annual costs would total up to $447,000 (Labor Enforcement and Compliance Fund).

- According to an analysis of the bill by the CHBRP, the bill would result in no impact to the coverage provided to Medi-Cal managed care plan beneficiaries or related premiums. CHBRP assumes that all over-the-counter contraceptives would be available under the pharmacy benefit. As of a to-be-determined date, all items covered under the pharmacy benefit for Medi-Cal managed care plans are paid for on a fee-for-service basis and are "carved out" of care provided by Medi-Cal managed care plans. Vasectomies are already covered without cost sharing under Medi-Cal.

SUPPORT: (Verified 5/21/21)

Essential Access Health (co-source)
NARAL Pro-Choice California (co-source)
National Health Law Program (co-source)
Access Reproductive Justice
ACLU California
American Association of University Women- California
American College of Obstetricians and Gynecologists District IX
APLA Health
Bienestar Human Services
Business & Professional Women of Nevada County
California Academy of Family Physicians
California Black Health Network
California Faculty Association
California Health+ Advocates
California Latinas for Reproductive Justice
California Nurse-Midwives Association
California Women's Law Center
Children's Hospital Los Angeles
Citizens for Choice
Courage California
End Hep C SF
End the Epidemics
Los Angeles LGBT Center
MPact Fijate Bien Program
National Association of Social Workers, California Chapter
National Center for Youth Law
National Council of Jewish Women Los Angeles
Plan C
Planned Parenthood Affiliates of California
Religious Coalition for Reproductive Choice California
SF AIDS Foundation
The Center for Health and Prevention
The Los Angeles Trust for Children's Health
Training in Early Abortion for Comprehensive Healthcare
Women's Foundation California
Women's Health Specialists

OPPOSITION: (Verified 5/21/21)

America's Health Insurance Plans
Association of California Life and Health Insurance Companies
California Association of Health Plans
California Catholic Conference

ARGUMENTS IN SUPPORT: NARAL Pro-choice California writes despite the progress made to expand access to family planning coverage and care, millions of Californians are not afforded the same benefits because the state contraceptive mandate is not currently applicable to their health plans. State workers, university employees, and college students may be denied their birth control option of choice without cost-sharing or restrictions. They also lack coverage for a full year's supply of self-administered contraceptives dispensed at once, like Californians enrolled in Knox-Keene regulated plans. It's time for California to modernize and expand our contraceptive equity laws to reduce barriers to contraceptive care, improve sexual and reproductive health outcomes, and create greater health equity. Access Reproductive Justice writes this bill removes barriers to sexual and reproductive health care and builds the power of Californians to demand health, justice, and dignity, and birth control is essential health care and California can and must advance proactive solutions to ensure that Californians get the birth control they want, when they need it, without delay. The American Civil Liberties Union writes that this bill makes California's contraceptive equity laws gender neutral. California Academy of Family Physicians writes that they fully support their patients' ability to access affordable contraception and birth control.

ARGUMENTS IN OPPOSITION: 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. 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. The California Catholic Conference requests amendments to existing law to expand the existing definition of religious employer.

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
5/22/21 13:04:00

****** END ******