Date of Hearing: July 6, 2021

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
SB 523 (Leyva) – As Amended May 3, 2021

SENATE VOTE: 32-5

SUBJECT: Health care coverage: contraceptives.

SUMMARY: Establishes the Contraceptive Equity Act of 2021, and expands coverage of contraceptives by a health care service plan (health plan) contract or health insurance policy issued, amended, renewed, or delivered on and after January 1, 2022, including requiring a health plan or health insurer to provide point-of-sale coverage for over-the-counter (OTC) U.S. Food and Drug Administration (FDA)-approved contraceptive drugs, devices, and products at in-network pharmacies without cost-sharing or medical management restrictions. Prohibits a health plan contract or disability insurance policy issued, amended, renewed, or delivered on or after January 1, 2022, with certain exceptions, from imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on vasectomy coverage, as specified, under conditions similar to those applicable to other contraceptive coverage. Requires health plans and insurance policies offered by public or private institutions of higher learning that directly provide health care services only to its students, faculty, staff, administration, and their respective dependents, approved on or after January 1, 2023, to comply with these contraceptive coverage requirements. Prohibits the California Public Employees' Retirement System (CalPERS) Board of Public Relations, the California State University (CSU), and the University of California (UC) from approving or renewing a health benefit plan that does not comply with the contraceptive coverage requirements of this bill and existing law, on and after January 1, 2022. Specifically, **this bill**:

Health Plan and Insurance Coverage Provisions

1) Requires a health plan contract or insurance policy, except for a specialized health plan contract or policy, as specified, to cover all of the following services and contraceptive methods (in addition to the contraceptive coverage in existing law) for all subscribers and enrollees or insureds:
   a) All FDA-approved contraceptive drugs, devices, and other products, including all FDA-approved contraceptive drugs, devices, and products available OTC without a prescription, except as provided in 2) and 3) below, as follows:
      i) Prohibits a health plan or insurer from requiring a prescription to trigger coverage of over-the-counter FDA-approved contraceptive drugs, devices, and products; and,
      ii) Requires a health plan or 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.
   b) Voluntary tubal ligation procedures; and,
   c) Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling.

2) Specifies that if there is no therapeutically equivalent generic substitute available in the market, a health plan or insurer is required to provide coverage without cost sharing for the original, brand name contraceptive.

3) Requires a health plan tor 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, if a covered therapeutic equivalent of a drug, device, or product is deemed medically inadvisable by the enrollee's or insured's provider. Allows medical inadvisability to include consideration 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. Authorizes the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI) to promulgate regulations establishing an easily accessible, transparent, and sufficiently expedient process that is not unduly burdensome, including timeframes, for an enrollee or insured, an enrollee's or insured's designee, or an enrollee's or insured's provider to request coverage of an alternative prescribed contraceptive.

4) Prohibits a health plan or insurer, except as otherwise authorized, from infringing upon an enrollee's or insured's choice of contraceptive drug, device, or product and shall not impose any restrictions or delays on the coverage required under this bill, including prior authorization, step therapy, or other utilization control techniques.

5) Prohibits the religious employer exclusion from applying to a contraceptive drug, device, procedure, or other product that is used for purposes other than contraception.

6) Limits the application of this bill to OTC FDA-approved contraceptive drugs, devices, and products and OTC birth control methods to those included as essential health benefits (EHBs), as specified.

7) Applies 2) to 7) above to health plan contracts and insurance policies issued, amended, renewed, or delivered on or after January 1, 2022.

8) Prohibits a health plan contract or insurance policy, issued, amended, renewed, or delivered on or after January 1, 2022, except for a grandfathered health plan or policy or a qualifying health plan or policy for a health savings account (HSA), from imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on vasectomy coverage provided under EHBs, as specified. Requires the carrier, for a qualifying health plan or policy for a HSA, to establish the plan's or insurer's cost-sharing for the coverage required pursuant to this bill and the minimum level necessary to preserve the enrollee's or insured's ability to claim tax-exempt contributions and withdrawals from the enrollee's or insured's HSA under Internal Revenue Service laws and regulations. Prohibits cost sharing from being imposed on a Medi-Cal beneficiary.

9) Prohibits a health plan or insurer from imposing any restrictions or delays on the coverage as required under this bill.

10) Requires benefits for an enrollee or insured to be the same for an enrollee's or insured's covered spouse and covered nonspouse dependents.

11) Applies this bill to Medi-Cal managed care plans that contract with the State Department of Health Care Services (DHCS), as specified.

12) Allows a religious employer to request a health plan contract or insurance policy without coverage for contraceptive methods that are contrary to the religious employer's religious tenets. Requires a health plan contract or policy, if so requested, to be provided without coverage for vasectomy services and procedures. Prohibits the exclusion from coverage under this bill from applying to a vasectomy service or procedure that is used for purposes other than contraception.

13) Defines a religious employer, for purposes of this bill, as an entity for which each of the following is true:
    a) The inculcation of religious values is the purpose of the entity;
    b) The entity primarily employs persons who share the religious tenets of the entity;
    c) The entity serves primarily persons who share the religious tenets of the entity; and,
    d) The entity is a nonprofit organization as described in the Internal Revenue Code of 1986, as amended.

14) Requires every religious employer that invokes the exemption provided under this this bill to provide written notice to prospective enrollees prior to enrollment with the plan, listing vasectomy as a service or procedure that the employer refuses to cover for religious reasons.

15) Prohibits this bill from being construed to deny or restrict in any way the DMHC or CDI's authority to ensure plan compliance with this bill when a plan or insurer provides coverage for contraceptive drugs, devices, and products; or, from being construed to require an individual or group health plan contract or insurance policy to cover experimental or investigational treatments.

16) Defines the following:
    a) Grandfathered health plan as set forth in the federal Patient Protection and Affordable Care Act (ACA); and,
    b) Provider as an individual who is certified or licensed the Business and Professions Code and the Health and Safety Code.

17) Specifies that a plan or policy directly operated by a bona fide public or private institution of higher learning that directly provides health care services only to its students, faculty, staff, administration, and their respective dependents, and that is approved on or after January 1, 2023, comply with the contraceptive coverage requirements of this bill and SB 999 (Pavley), Chapter 499, Statutes of 2016.

Employer Provisions

18) Prohibits the CalPERS board, beginning January 1, 2022, from approving a health benefit plan contract for employees that does not comply with the contraceptive coverage requirements of this bill, and SB 999.

19) Prohibits an employer from failing or refusing to hiring or discharging 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 decisionmaking, including a decision to use or access a particular drug, device, or medical service.

20) Provides that an employer, or any person acting on behalf of an employer, who takes any adverse employment action against an employee in violation of 19) above is liable to the aggrieved employee, as specified.

21) Specifies that any contract or agreement, express or implied, made by an employee to waive the benefits of this bill is null and void.

22) Requires an employer that requires compliance with an employee handbook to include in the handbook a notice of the employee rights and remedies under this bill.

23) Specifies that the rights and remedies conferred by this bill are in addition to, and not in limitation of, any right or remedy lawfully granted under the California Fair Employment and Housing Act as specified.

24) Provides that this bill does not create a new basis upon which an employee can accrue or use benefits relating to paid or protected time off.

25) Prohibits the UC and CSU, beginning January 1, 2022, from approving a health benefit plan contract for employees that does not comply with the contraceptive coverage requirements of this bill and SB 999 (Pavley).

26) Makes various findings and declarations, including that the Legislature intends to reduce sexual and reproductive health disparities and ensure greater health equity by providing a pathway for more Californians to get the contraceptive care they want, when they need it, without inequitable delays or cost barriers.

27) Makes other technical, clarifying, and conforming changes.

EXISTING LAW:

1) Establishes the DMHC to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and CDI to regulate health insurers under the Insurance Code.

2) Establishes the Medi-Cal program, administered by DHCS, under which qualified low-income persons receive health care benefits and, in part, governed and funded by federal Medicaid program provisions.

3) Requires a health plan contract, or a group or individual policy of disability insurance, except for a specialized health plan contract or a specialized health insurance policy, that is issued, amended, renewed, or delivered on or after January 1, 2016, to provide coverage for all of the following services and contraceptive methods for women:
   a) All FDA-approved contraceptive drugs, devices, and other products for women, including all FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the enrollee's or insured's provider;
   b) Voluntary sterilization procedures;
   c) Patient education and counseling on contraception; and,

   d) Follow-up services related to the drugs, devices, products, and procedures, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

4) Prohibits a health plan or disability insurer from imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to contraceptive coverage, except in the case of a grandfathered health plan. Prohibits cost sharing from being imposed on any Medi-Cal beneficiary.

5) Permits a religious employer to request a health plan contract or disability insurance policy that offers no coverage for FDA-approved contraceptive methods that are contrary to the religious employer's religious tenets, and requires a health plan contract or disability insurance policy to be provided without coverage for contraceptive methods, if requested. Defines religious employer as an entity for which each of the following is true:
   a) The inculcation of religious values is the purpose of the entity;
   b) The entity primarily employs persons who share the religious tenets of the entity;
   c) The entity serves primarily persons who share the religious tenets of the entity; and,
   d) The entity is a nonprofit organization as described in the Internal Revenue Code of 1986, as amended.

6) Establishes as California's EHBs as the Kaiser Small Group HMO plan, along with the following 10 federally mandated benefits under the federal ACA, as well as other existing state mandated benefits:
   a) Ambulatory patient services;
   b) Emergency services;
   c) Hospitalization;
   d) Maternity and newborn care;
   e) Mental health and substance use disorder services, including behavioral health treatment;
   f) Prescription drugs;
   g) Rehabilitative and habilitative services and devices;
   h) Laboratory services;
   i) Preventive and wellness services and chronic disease management; and,
   j) Pediatric services, including oral and vision care.

7) Permits a pharmacist to dispense no more than a 90-day supply of a dangerous drug other than a controlled substance pursuant to a valid prescription that specifies an initial quantity of less than a 90-day supply followed by periodic refills of that amount, if specified requirements are satisfied, such as the patient has completed an initial 30-day supply of the dangerous drug. Prohibits a pharmacist from dispensing a greater supply of a dangerous drug if the prescriber personally indicates, either orally or in his or her own handwriting, "No change to quantity," or words of similar meaning.

8) Permits a pharmacist to furnish self-administered hormonal contraceptives in accordance with standardized procedures or protocols developed and approved by both the Board of Pharmacy and the Medical Board of California in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other appropriate entities.

9) Requires the standardized procedure or protocol in 8) above to require that the patient use a self-screening tool that will identify patient risk factors for use of self-administered hormonal

contraceptives, based on the current United States Medical Eligibility Criteria for Contraceptive Use developed by the federal Centers for Disease Control and Prevention, and that the pharmacist refer the patient to the patient's primary care provider or, if the patient does not have a primary care provider, to nearby clinics, upon furnishing a self-administered hormonal contraceptive, or if it is determined that use of a self-administered hormonal contraceptive is not recommended.

10) Requires the pharmacist to provide the patient a standardized fact sheet that includes, but is not limited to, the indications and contraindications for use of the drug, the appropriate method for using the drug, the need for medical follow-up, and other appropriate information, developed, as specified.

11) Requires a health plan or a health insurance policy issued, amended, renewed, or delivered on or after January 1, 2017, to cover up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives when dispensed at one time for an enrollee or insured at one time by a provider, pharmacist, or at a location licensed or authorized to dispense drugs or supplies. Provides that a health plan contract or an insurance policy is not required to cover contraceptives provided by an out-of-network provider, pharmacy, or other location, except as authorized by state or federal law or by the plan or insurer's policies governing out-of-network coverage. Prohibits a health plan or health insurer, in the absence of clinical contraindications, from imposing utilization controls limiting the supply of FDA-approved, self-administered hormonal contraceptives that may be furnished by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies to an amount that is less than a 12-month supply.

12) Requires a pharmacist to dispense, at a patient's request, up to a 12-month supply of an FDA-approved, self-administered hormonal contraceptive pursuant to a valid prescription that specifies an initial quantity followed by periodic refills. Authorizes a pharmacist furnishing an FDA-approved, self-administered hormonal contraceptive, pursuant to the authorization described above, to furnish up to a 12-month supply at one time at the patient's request.

FISCAL EFFECT: According to the Senate Appropriations Committee, UC would total $895,000 annually across its three insurance plans (General Fund (GF)). CSU system indicates that the bill would result in unknown cost increases (GF) 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. This 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 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 a California Health Benefits Review Program (CHBRP) analysis, this 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.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, this bill, the Contraceptive Equity Act of 2021, 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.

2) **BACKGROUND.**

   a) **Health Insurance Coverage**. According to CHBRP, California's Contraceptive Coverage Equity Act of 2014 (Act) codified ACA mandates regarding contraceptive coverage for women into state law. The Act requires commercial health plans and policies and Medi-Cal managed care plans to provide coverage for all prescribed FDA-approved contraceptive drugs, devices, and products for women. Plans and policies must cover, without cost sharing, at least one form of contraception within each FDA-approved method. Generally, health plans and policies are not required to cover brand-name contraceptives if they cover an FDA-approved generic therapeutic equivalent. However, if the generic therapeutic equivalent is not available, the plan or policy must cover the brand-name contraceptive without cost sharing. California law currently does not require coverage for OTC contraception without a prescription, thus enrollees must pay the full cost of nonprescription OTC contraceptives out of pocket. Existing law also requires coverage for voluntary sterilization, contraceptive education, counseling and related follow-up care for women. Male sterilization is not required to be covered under California law; however, the vast majority of California's largest health insurance providers do provide coverage. Medi-Cal also provides full coverage for male sterilization without cost sharing. As it is a covered benefit for many plans and policies, male sterilization (vasectomies) may have some cost sharing associated with it, depending on the type of coverage. Religious employers whose primary purpose is the inculcation of religious values and that meet other specifications may be exempt from the state mandate. In 2016, California passed SB 999, which requires health plans and policies to cover a 12-month supply of self-administered hormonal contraceptives to women when dispensed at one time, without cost sharing. SB 999 also authorizes pharmacists to furnish such contraceptives under specified conditions. To narrow the gap between insured and uninsured women and men in California, DHCS developed the Family Planning, Access, Care, and Treatment Program (FPACT) program. FPACT provides publicly funded coverage for comprehensive clinical family planning services for any person with a family income at or below 200% of the federal poverty level, regardless of age or immigration status. The program serves approximately 1.1 million residents. Individuals who have other health coverage, including Medi-Cal fee-for-service and managed care, can be eligible for FPACT benefits. Coverage includes family planning–related services and male and female sterilization; all FDA-approved contraceptive drugs (i.e., prescription and OTC), devices, and supplies; and health education and counseling services Utilization management.

Existing California law generally prohibits health plans and insurers from imposing restrictions or delays on coverage for contraceptive drugs, devices, and products. This bill specifies that these restrictions or delays include prior authorization, step therapy, and other utilization control techniques. Current law also prohibits health plans and policies from imposing utilization controls or other forms of medical management in limiting the supply of FDA-approved self-administered hormonal contraceptives that may be dispensed to an enrollee. This bill would expand this prohibition on medical management to include coverage for FDA-approved OTC contraceptives, Some contraceptive drugs, devices, or products may be deemed medically inadvisable for a patient by their health care provider. In these circumstances, existing law allows health plans and policies to impose utilization management procedures on coverage of an alternative contraceptive. "Utilization management procedures" is not defined under current law; however, the term generally refers to prior authorization, step therapy, and other utilization management techniques. This bill would prohibit health plans and policies from allowing such practices in these situations.

b) CHBRP analysis. AB 1996 (Thomson), Chapter 795, Statutes of 2002, requests the UC 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 EHBs, and legislation that impacts health insurance benefit designs, cost sharing, premiums, and other health insurance topics. Amendments adopted on May 3rd now requires coverage without cost sharing for OTC birth control methods obtained at in-network pharmacies and no longer applies to out-of-network pharmacies or retailers. The May 3 amendments also removed the authority for health plans and policies to establish frequency and quantity limits for coverage of contraceptive methods. OTC birth control methods are now limited to those included as EHBs. This bill now explicitly mandates coverage without cost sharing for vasectomies, with an exemption for grandfathered and HSA-eligible plans and policies. CHBRP had already interpreted the bill to require coverage for vasectomies and assumed that grandfathered and HSA-eligible plans and policies would continue to have cost sharing postmandate. All cost estimates were based on expected utilization rather than frequency or quantity limits. CHBRP states the following in its analysis of this bill:

i) Enrollees covered. CHBRP estimates that postmandate, there would be a cost shift and increase in utilization of nonprescription OTC contraceptives and vasectomies and related clinical services due to the elimination of cost sharing for vasectomies and out of pocket costs for nonprescription OTC contraceptives proposed under this bill.

ii) Impact on expenditures. CHBRP estimates at baseline 0% of enrollees have coverage of nonprescribed OTC contraceptives, and 100% have coverage for vasectomies and related clinical services. Among commercial/CalPERS enrollees, vasectomies and related clinical services have an average of $341 in cost sharing; this is an average across all enrollees, including enrollees in PPO and HMO plans. CHBRP assumes that increased use of nonprescription OTC contraceptives and vasectomies would result in a reduced number of unintended pregnancies. Due to insufficient evidence available to estimate the effectiveness of insurance coverage of nonprescription OTC contraceptives, CHBRP is unable to estimate changes in sexually transmitted

infections (STIs) as a result of this bill. According CHBRP, 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. At baseline, CHBRP estimates that there are 4,173 commercial enrollees undergoing tubal ligation procedures. CHBRP assumes that for every 100 vasectomies, there would be 93.5 fewer tubal ligations, assuming the sexual partner has health insurance regulated by the DMHC or CDI. 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. The greatest change in premiums would be for large-group plans in the DMHC-regulated market (a decrease of $0.44 per member per month). 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.

(1) Medi-Cal. CHBRP assumes that all OTC 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. Therefore, this bill would result in no impact to the coverage provided to Medi-Cal managed care plan beneficiaries or related premiums.

(2) CalPERS. Among CalPERS HMO plans, there is an estimated decrease of $0.44 in per member per month premiums.

(3) Number of Uninsured in California. CHBRP expects no measurable change in the number of uninsured persons due to the enactment of this bill since the change in average premiums does not exceed 1% for any market segment.

iii) EHBs. Coverage for contraceptives is currently required as part of EHBs in California. However, existing law only requires coverage of female contraception. Thus, coverage of male contraception, as mandated by this bill, would require coverage for a new benefit that may exceed EHBs in California. It should be noted that this bill was subsequently amended to clarify that coverage is limited to EHBs.

iv) Medical effectiveness. CHBRP investigated findings from evidence on: (1) effectiveness of contraceptive methods at preventing unplanned pregnancies and transmission of STIs; (2) the impact of point-of-sale coverage and reimbursement on utilization of nonprescription OTC contraceptives; (3) the impact of utilization management on contraceptive utilization; and, (4) potential side effects of nonprescription OTC contraceptive utilization. Over the course of a year, sexually active women 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:

(1) *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 that spermicide is not effective in preventing transmission of STIs/HIV;

(2) *Insufficient evidence* to determine how insurance coverage for contraceptives affected by this bill (i.e., nonprescription OTC contraceptives and vasectomy) impacts contraceptive utilization; and,

(3) *Insufficient evidence* on the impact of utilization management policies on contraceptive utilization.

v) Utilization. CHBRP estimated utilization would increase by 4.8% for nonprescription OTC contraceptives and 2.1% for vasectomies due to these reductions in costs. CHBRP estimates that, among commercial enrollees:

(1) At baseline, 18,755 individuals use nonprescription OTC female barrier contraceptives (e.g., sponge, female condom, spermicide). Postmandate, 19,513 individuals would use female nonprescription OTC contraceptives, an increase of 4.05%;

(2) At baseline, 106,492 individuals use emergency contraceptives. Postmandate, 110,794 individuals would use emergency contraceptives, an increase of 4.04%;

(3) At baseline, a total of 2,080,696 enrollees use nonprescription OTC male barrier contraceptives (i.e., male condoms). Postmandate, 2,164,864 individuals would use male condoms, an increase of 4.05%; and,

(4) At baseline, a total of 14,204 individuals obtain vasectomies and related clinical services. Postmandate, an additional 252 enrollees would obtain vasectomies and related clinical services for a total of 14,455 enrollees, an increase of 1.77%.

vi) 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. CHBRP projects that this bill would increase utilization of male condoms by approximately 84,169 enrollees but is unable to estimate a quantitative impact on STI rates due to increased access to male condoms; however, it stands to reason that some of the 84,169 enrollees (and their partners) may be at lower risk of acquiring or transmitting an STI and be at lower risk for infection-related adverse health outcomes. 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.

vii) Long-term impacts. CHBRP estimates annual utilization of induced nonprescription OTC contraceptives and vasectomies after the initial 12 months from the enactment

of this bill would likely stay similar to utilization estimates during the first 12 months postmandate. Utilization changes may occur if new nonprescription OTC medications or procedures change the landscape for enrollees, or social marketing programs influence enrollee behavior; however, CHBRP is unable to predict these types of changes. Similarly, health care utilization due to improved reproductive health services may change in the long term. Assuming that this bill increases utilization of contraceptives beyond the first year postmandate, there may be a decrease in the rate of unintended pregnancies, abortions, and STI transmissions in the long-term. As such, there may also be a decrease in the adverse health outcomes associated with conditions. In addition, the potential decrease in the rate of unintended pregnancies may allow females to delay childbearing and pursue additional education, spend additional time in their careers, and have increased earning power.

c) Other states. According to CHBRP, sixteen states and the District of Columbia (DC) codified into state law the provisions of the ACA mandate that prohibit cost sharing for contraceptives. Nine states and DC prohibit insurance plans from imposing restrictions and delays, or the use of medical management techniques that restrict access to contraceptives. Similar state legislation has been introduced this year in Alaska, Hawaii, Kentucky, Minnesota, Rhode Island, Utah, and West Virginia. Some states would also include provisions similar to those mandated under California's SB 999 (Pavley) and SB 1053 (Mitchell), Chapter 576, Statutes of 2014. At the federal level, H.R. 239 of 2021 prohibits the Department of Veteran Affairs from requiring veterans to pay for any contraceptive item that is required to be covered by health plans without cost sharing.

3) SUPPORT. Essential Access Health, NARAL Pro Choice California, and the National Health Law Program Essential Access Health, NARAL Pro-Choice California, and National Health Law Program, cosponsors of this bill, write that this bill provides a comprehensive approach to ensure greater contraceptive equity in California while saving health care costs. They state that this bill seeks to expand and modernize birth control access in our state, regardless of an individual's gender identity, insurance coverage status, or where they work or go to school. California enacted SB 1053 (Mitchell), Chapter 576, Statutes of 2014,the Contraceptive Coverage Equity Act, in 2014 to build on existing policy and codify the Affordable Care Act's contraceptive coverage mandate into state law. In addition, SB 999 was enacted to require most health insurance plans in California to cover a year's supply of birth control dispensed at once. 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, and lack coverage for a full year's supply of self-administered contraceptives dispensed at once. Health disparities in reproductive health outcomes also persist among Black, Indigenous and People of Color, including disproportionate rates of unintended pregnancy, infant and maternal mortality, and sexually transmitted diseases (STDs). The COVID-19 public health emergency has further illuminated the structural inequities that disproportionately affect youth, low-income people and communities of color in accessing birth control services. A report by the Guttmacher Institute revealed that 38% of Black women and 45% of Latinas, compared to 29% of white women, now face difficulties accessing birth control as a result of the pandemic. The sponsors conclude that lower-income women were also more likely than higher-income women to

report having experienced delays or being unable to get contraceptive care because of the pandemic (36% vs. 31%).

4) **OPPOSITION.** California Association of Health Plans (CAHP), the Association of California Life and Health Insurance Companies (ACLHIC), and America's Health Insurance Plans (AHIP) write that this bill will lead to higher premiums, harming affordability and access for small businesses and individual market consumers. CAHP, ACLHIC, and AHIP contend that 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.

5) **RELATED LEGISLATION**. SB 306 (Pan) permits a pharmacist to dispense a drug to treat STDs without the name of an individual for whom a drug is intended if the prescription includes the words "expedited partner therapy" or the letters "EPT." Requires every health care service plan (health plan) contract or health insurance policy issued, amended, renewed or delivered on or after January 1, 2022 to provide coverage for home test kits for STD, including the laboratory costs of processing the kit, that are deemed medically necessary or appropriate and ordered directly by a clinician or furnished through a standing order for patient use based on clinical guidelines and individual health needs. Expands the scope of benefits in Medi-Cal and the FPACT to include STD home test kits, including the laboratory costs of processing the kit, that are deemed medically necessary or appropriate and ordered directly by an enrolled Medi-Cal or FPACT clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs. SB 306 is pending in Assembly Business and Professions Committee.

6) **PREVIOUS LEGISLATION.**

   a) SB 406 (Pan), Chapter 302, Statutes of 2020, codifies existing ACA law into state law that prohibits lifetime or annual limits in health care service plan and health insurance policies and requires coverage of preventative health services without cost sharing.

   b) SB 999 requires a health plan or a health insurance policy issued, amended, renewed, or delivered on or after January 1, 2017, to cover up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives when dispensed at one time for an enrollee or insured at one time by a provider, pharmacist, or at a location licensed or authorized to dispense drugs or supplies.

   c) SB 1053 requires a health plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2016, to provide coverage for women for all prescribed and FDA-approved female contraceptive drugs, devices, and products, as well as voluntary sterilization procedures, contraceptive education and counseling, and related follow-up services. Prohibits a nongrandfathered plan contract or health insurance policy from imposing any cost-sharing requirements or other restrictions or delays with respect to this coverage, as specified.

   d) SB 493 (Hernandez), Chapter, 469, Statutes of 2013, authorizes advanced practice pharmacists to perform other functions, including, among other things, furnishing self-administered hormonal contraceptives, nicotine replacement products, and prescription

medications not requiring a diagnosis that are recommended for international travelers, as specified.

7) **DOUBLE REFERRAL**. This bill is double referred, it pass he Assembly Committee on Labor and Employment on June 22, 2021 with a 5-1 vote.

8) **AUTHOR'S AMENDMENTS.** The author proposes the following amendments to address CDI's technical amendments:

   a) Clarify that a health benefit plan or contract cover contraceptives as required under this bill;

   b) Clarify coverage of tubal ligation, hysterectomy, and other similar sterilization procedures;

   c) Clarify coverage of vasectomy services and procedures;

   d) Specify that a request for coverage under this bill that is submitted by an enrollee or insured, enrollee's or insured's designee, or prescribing provider be approved by the health plan or insurer within specified time frames;

   e) Delete " in the absence of clinical contractions" from the provisions that prohibit a health plan or insurer from imposing utilization controls; and,

   f) Make other technical and conforming changes.

REGISTERED SUPPORT / OPPOSITION:

Support

Essential Access Health (cosponsor)
NARAL Pro Choice California (cosponsor)
National Health Law Program (cosponsor)
Access Reproductive Justice
ACLU California Action
American Academy of Pediatrics, California
American Association of University Women (AAUW) San Jose
American Association of University Women - California
American Civil Liberties Union/Northern California/Southern California/San Diego and Imperial Counties
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 Alliance for Retired Americans
California Black Health Network
California Faculty Association
California Hepatitis Alliance (CALHEP)
California Latinas for Reproductive Justice

California Nurse-Midwives Association (UNREG)
California Society of Health-System Pharmacists
California Women's Law Center
Californiahealth+ Advocates
Children's Hospital Los Angeles
Citizens for Choice
Community Clinic Association of Los Angeles County (CCALAC)
Courage California
End Hep C SF
End the Epidemics: Californians Mobilizing to End HIV, Viral Hepatitis, STIs, and Overdose
Los Angeles LGBT Center
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
San Francisco AIDS Foundation
The Los Angeles Trust for Children's Health
Training in Early Abortion for Comprehensive Healthcare
Women Organized to Respond to Life-threatening Diseases (WORLD)
Women's Foundation California
Women's Health Specialists

Opposition

America's Health Insurance Plans
Association of California Life & Health Insurance Companies
California Association of Health Plans
California Catholic Conference
California Chamber of Commerce

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