SENATE THIRD READING
SB 523 (Leyva)
As Amended August 15, 2022
Majority vote

SUMMARY

Establishes the Contraceptive Equity Act of 2022, 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, 2024, 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. Specifies that a prescription is not required to trigger coverage of OTC FDA-approved contraceptive drugs, devices, and products. Prohibits a health plan contract or disability insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, 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 a health plan or insurer to defer to the provider's determination and judgement and provide coverage for the alternative prescribed drug, device, or service without cost-sharing, if a covered therapeutic is deemed medically inadvisable by the enrollee or insured's provider, as specified. Includes, for purposes of this bill, Medi-Cal managed care plans (MCMPs), to the extent that the benefits described are made the financial responsibility of the MCMPs and if some or all of the described benefits are not the MCMP's financial responsibility, then those benefits are available on a fee-for-service basis, as specified. 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, issued, amended, renewed, or delivered on or after specified dates, 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, 2024. Amends existing law, under the Fair Employment and Housing Act, to include, among other provisions, protection for reproductive health decisionmaking, with respect to the opportunity to seek, obtain, and hold employment without discrimination. Defines reproductive health decisionmaking as, including but not limited to, a decision to use or access a particular drug, device, product, or medical service for reproductive health, as specified.

COMMENTS

1) *Health Insurance Coverage.* According to the California Health Benefits Review Program (CHBRP), California's Contraceptive Coverage Equity Act of 2014 (Act) codified federal Patient Protection and Affordable Care Act 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 (Pavley), Chapter 499, Statutes of 2016, 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.

2) *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 essential health benefits (EHBs), and legislation that impacts health insurance benefit designs, cost sharing, premiums, and other health insurance topics. Amendments adopted on May 2021 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 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 health savings

account (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 (previous version):

a) 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.

b) 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 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 Department of Managed Health Care (DMHC) or California Department of Insurance (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.

   i) 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 MCMP. Vasectomies are already covered without cost sharing under Medi-Cal. Therefore, this bill would result in no impact to the coverage provided to MCMP beneficiaries or related premiums.

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

iii) 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.

According to the Author
This bill, the Contraceptive Equity Act of 2024, 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.

Arguments in Support
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 the Act in 2014 to build on existing policy and codify the Patient Protection and 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. 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%).

Arguments in Opposition
The California Catholic Conference, in a previous version of this bill, is oppose unless amended, is requesting amendments for a clearer and respected definition for "religious employer" and a clearer distinction for the exceptions. 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.

FISCAL COMMENTS

According to Assembly Appropriations Committee,

1) Costs between approximately $250,000 and $470,000 annually to the Division of Labor Standards Enforcement (DLSE) to investigate discrimination or retaliation complaints and

enforce cases. DLSE notes it has no direct frame of reference to assume how many people may experience discrimination or retaliation and also file a complaint, but estimates between 50 to 100 new claims as a result of this bill (Special Fund).

2) Costs of approximately $895,000 annually to UC to make changes across the three insurance plans it operates (General Fund).

3) Costs of an unknown amount to CSU, if employer contributions increase as a result of this bill. CSU notes this bill does not affect its student health centers, which already provide no-cost birth control options for students.

4) Costs of approximately $7,000 in fiscal year (FY) 2021-22 and $17,000 in FY 2022-23 to CDI to review health insurance polies and adopt regulations (Special Fund).

5) Costs of approximately $100,000 in FY 2021-22, $407,000 in FY 2022-23 and $300,000 ongoing to DMHC to review health plan polices, adopt regulations and provide enforcement (Special Fund).

6) Costs of an unknown amount to CalPERS. CalPERS indicates all of its plans would incur some cost for the elimination of member cost sharing for OTC contraception and sterilization procedures. As an example, CalPERS members in PPO plans paid about $137,000 in cost sharing for tubal ligation and vasectomy procedures in 2019. This member-paid amount would be absorbed by the health plans under this bill. However, upfront costs to plans could be offset in the long-term, assuming utilization of these benefits increases, thus decreasing the number of unintended pregnancies and related services.

7) According to an analysis of this bill by CHBRP, this bill would not impact the coverage provided to MCMP beneficiaries or related premiums. CHBRP assume all OTC contraceptives would be available under the pharmacy benefit and vasectomies are already covered without cost sharing under Medi-Cal.

VOTES

SENATE FLOOR: 32-5-3
YES: Allen, Archuleta, Atkins, Becker, Bradford, Caballero, Cortese, Dahle, 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: Borgeas, Jones, Nielsen, Ochoa Bogh, Wilk
ABS, ABST OR NV: Bates, Grove, Melendez

ASM LABOR AND EMPLOYMENT: 5-1-1
YES: Kalra, Lorena Gonzalez, Jones-Sawyer, Reyes, Ward
NO: Flora
ABS, ABST OR NV: Seyarto

ASM HEALTH: 11-2-2
YES: Wood, Aguiar-Curry, Arambula, Calderon, Carrillo, Maienschein, McCarty, Nazarian, Luz Rivas, Rodriguez, Santiago
NO: Bigelow, Flora

ABS, ABST OR NV: Mayes, Waldron

ASM APPROPRIATIONS: 13-3-0
YES: Holden, Bryan, Calderon, Arambula, Davies, Mike Fong, Gabriel, Eduardo Garcia, Levine, Quirk, Robert Rivas, Akilah Weber, McCarty
NO: Bigelow, Megan Dahle, Fong

UPDATED

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