SENATE COMMITTEE ON LABOR, PUBLIC EMPLOYMENT AND RETIREMENT
Senator Dave Cortese, Chair
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Bill No:	SB 523	**Hearing Date:**	April 5, 2021
Author:	Leyva		
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Urgency:	No	**Fiscal:**	Yes
Consultant:	Glenn Miles		

SUBJECT: Health care coverage: contraceptives

KEY ISSUE

Should the Legislature prohibit the California Public Employees' Retirement System (CalPERS) and the University of California (UC) from approving health benefit plan contracts for employees that do not comply with specified contraceptive benefit mandates; require health plans and insurance policies regulated under the Knox-Keene Act or by the California Department of Insurance to provide improved contraceptive benefits; provide employees of religious employers employment protections if they obtain contraceptive benefits from another source; and require religious employers to cover contraceptive products when not used for contraception.

ANALYSIS

Existing law:

1) Authorizes CalPERS to contract with carriers for health benefit plans or approve health benefit plans offered by employee organizations, to provide health benefits to state employees, annuitants, and other employees of public agencies that contract with CalPERS for health benefits. CalPERS may also administer self-funded, partially self-funded, or minimum premium health benefit plans (Government Code § 22850 et seq.).

2) Requires CalPERS to approve any employee association health benefit plan that CalPERS approved in the 1987–88 contract year or prior, provided the plan continues to meet the minimum standards prescribed by CalPERS. The trustees of an employee association health benefit plan are responsible for providing health benefit plan administration and services to its enrollees (GC § 22850 (g) (1)).

3) Requires CalPERS to adopt all necessary rules and regulations pursuant to the Administrative Procedures Act to carry out its duties to provide health benefit coverage and administer the Public Employees Medical and Hospital Care Act (PEMHCA) (GC § 22796).

4) Provides, under CalPERS regulations, minimum standards for health benefits plans; minimum standards for health carriers; and minimum scope and content of basic health benefits plans, as specified (2 CCR § 599.508 – 599.510).

5) Requires, under the federal Patient Protection and Affordable Care Act (ACA), a non-grandfathered group health plan and a health insurance issuer offering group or individual

insurance coverage to provide coverage, without imposing cost-sharing requirements, for certain preventive services, including those preventive care and screenings for women provided in specified guidelines. The ACA requires the plans and issuers to provide coverage without cost-sharing for all federal Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed by a provider, except as specified (42 USC § 18022 et seq.).

6) Regulates self-funded health plans provided by private employers to their employees under the federal Employee Retirement Income Security Act (ERISA). ERISA generally preempts state regulation but specifically contains a partial waiver of preemption so states can apply health and insurance regulations to private sector plans (29 USC. § 1001 et seq.).

7) Provides state regulation of health plans, as defined, through the Department of Managed Health Care (DMHC)'s licensing authority under the Knox-Keene Act and regulates health insurance policies, as defined, through the California Department of Insurance (CDI) (California Health & Safety Code §1340 et seq. and California Insurance Code § 106 et seq.).

8) Requires a health care service 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 (HSC § 1367.25 and CIC § 10123.196).

9) Prohibits a non-grandfathered plan contract or health insurance policy from imposing any cost-sharing requirements or other restrictions or delays with respect to the mandated coverage, as specified (HSC § 1367.25 (b) (2) and CIC § 10123.196 (b) (2)).

10) Authorizes a pharmacist to dispense, at a patient's request, up to a 12-month supply of an FDA-approved, self-administered hormonal contraception pursuant to a valid prescription that specifies an initial quantity followed by periodic refills (Business and Professions Code § 4064.5 (f) (2)).

11) Requires every health care service plan contract 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 or furnished at one time for an enrollee by a provider, pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies (HSC § 1367.25 (d) (1) and CIC § 10123.196 (f) (1)).

12) Does not require a health care service plan to cover all therapeutically equivalent versions of a contraceptive drug, device, or product approved by the FDA, as specified, as long as the plan covers at least one version without cost-sharing. (HSC § 1367.25 (b) (2) (B) and CIC § 10123.196 (b) (2) (B)).

13) Requires a health care service plan to provide coverage for a prescribed contraceptive drug, device, or product without cost-sharing, subject to a plan's utilization management procedures, if the enrollee's provider deems a covered therapeutic equivalent of a drug,

device, or product is medically inadvisable or is not available (HSC § 1367.25 (b) (2) (C) and CIC § 10123.196 (b) (2) (C)).

14) Provides an exemption from the mandate to provided contraceptive coverage to a religious employer, as specified (HSC § 1367.25 (c) and CIC § 10123.196 (e)).

15) Establishes the University of California (UC) as a public trust to be administered by the Regents of the UC and grants the Regents full powers of organization and government, subject only to such legislative control as may be necessary to insure security of its funds, compliance with the terms of its endowments, statutory requirements around competitive bidding and contracts, sales of property and the purchase of materials, goods and services (Cal. Const., art. IX, § 9).

This bill:

1) Makes several legislative findings and declarations, as specified, 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. This includes a pathway to no-cost coverage for Californians whose employer-based health insurance plan may exclude contraceptive care under existing California law.

2) Mandates expanded contraceptive coverage for all health plans and health insurance regulated by DMHC and California Insurance Code (CIC), as specified.

3) Prohibits CalPERS and the University of California from approving a health benefit plan contract for employees that does not comply with the bill's respective Health & Safety Code and CIC contraceptive coverage requirements.

4) Includes contraceptives for men in mandated contraceptive coverage.

5) Prohibits a health care service plan from requiring a prescription to trigger coverage of over-the-counter FDA-approved contraceptive drugs, devices, and products.

6) Requires a health care service plan to provide point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and products at in-network pharmacies without cost-sharing or medical management restrictions and reimburse enrollees for out-of-pocket costs for over-the-counter birth control methods purchased at any out-of-network pharmacy in California without medical management restrictions.

7) Authorizes a health care service plan to limit the frequency and define quantities it provides specified contraceptive benefits.

8) Augments existing requirements for general patient education and counseling on contraception to specifically require coverage for clinical services related to the provision or use of contraception, including consultations, examinations, procedures, ultrasound, anesthesia, patient education, and counseling.

9) Modifies the exemption for health savings accounts from the prohibition on cost sharing to the minimum level necessary to preserve the enrollee's ability to claim tax-exempt contributions and withdrawals from the enrollee's health savings account under Internal Revenue Service laws and regulations.

10) Requires a health care service plan to provide coverage without cost sharing for the original, brand name contraceptive if there is no therapeutically equivalent generic substitute available in the market.

11) Requires a health care service plan to defer to the determination and judgment of the attending provider and provide coverage for an alternative prescribed contraceptive drug, device, product, or product without cost-sharing if the enrollee's provider deems a covered therapeutic equivalent of a drug, device, or product medically inadvisable, as specified.

12) Requires DMHC to promulgate regulations establishing an easily accessible, transparent, and sufficiently expedient process that is not unduly burdensome, including timeframes, for an enrollee, an enrollee's designee, or an enrollee's provider to request coverage of an alternative prescribed contraceptive.

13) Prohibits a health care service plan from infringing upon an enrollee's choice of contraceptive drug, device, or product and from imposing any restrictions or delays on the coverage, as specified, including prior authorization, step therapy, or other utilization control techniques.

14) Modifies the existing coverage exemption for religious employers such that an exclusion from required contraceptive coverage does not apply to a contraceptive drug, device, procedure, or other product that one uses for purposes other than contraception.

15) Prohibits a religious employer that invokes the exemption from the mandated contraceptive coverage from discriminating, firing, or enforcing other workplace punishment against an employee based on the employee's decision to independently obtain contraceptive coverage, care, or prescriptions outside of the employer-based plan.

16) Applies its changes to current law only to a health care service plan contract that one issues, amends, renews, or delivers on or after January 1, 2022.

17) Makes parallel changes identical to those discussed above to health care insurance policies regulated by CDI.

18) Provides that this bill does not create a reimbursable local mandate, as specified.

COMMENTS

1. Background

This bill appears to improve and codify in state law contraceptive benefits mandated by the federal ACA in state regulated health plans and insurance policies and to extend these contraceptive benefit mandates to plans that for constitutional, jurisdictional, organizational, and other reasons federal and state law may exempt or accommodate. It also provides employment protections to employees of religious employers who seek contraceptive benefits elsewhere and requires religious employers to cover contraceptive benefits not used for contraception.

Federal Law – ACA – A benefit floor with gaps

The ACA includes female contraception in a list of covered preventive services that ACA regulated plans must provide without enrollee cost sharing. The federal mandate applied to all new health insurance plans in all states, beginning in August of 2012. Before the federal mandate was implemented, 28 states had their own mandates that required health insurance plans to cover prescription contraceptives if they covered other prescription drugs, but the federal mandate was unique in prohibiting any enrollee cost-sharing.

Under the Trump administration, the federal government issued regulations that broadened exemptions and accommodations from the contraceptive benefit mandate for employers based on sincerely held moral or religious beliefs. Several states, including California, sued the federal government and a federal judge has stayed the new regulations pending the outcome of the litigation.

In response to the Trump era regulations and in the event the regulations are upheld, comprehensive contraceptive benefit supporters initiated state level legislation to protect ACA coverage mandates through state law. In 2014, California passed the Contraceptive Coverage Equity Act, effective January 1, 2016, which requires that relevant health plans provide coverage for FDA-approved contraceptive drugs, devices and products as well as voluntary sterilization, contraceptive education, counseling and related follow-up care for women. Plans must cover, without cost sharing, at least one form of contraception within each FDA-approved method. The law applies to health insurance plans and policies regulated by one of the state's regulators, the DMHC or CDI and includes Medi-Cal managed care plans regulated by DMHC.

DMHC and CDI have some regulatory authority over private sector self-insured PPO plans by virtue of ERISA's limited waiver of preemption. However, out of comity for constitutional principles of federalism, ERISA does not apply to state health plans that provide health benefit coverage for the state's own employees. Theoretically, CalPERS' self-insured PPO plans are exempt from the ACA and state coverage mandates. In practice, CalPERS' plans typically comply with or exceed those mandates.

This bill continues state government efforts to ensure and improve ACA contraceptive coverage benefits in the event that the Trump era federal regulations weaken the ACA mandates.

CalPERS Health Plan and State Employee Association Plans

CalPERS negotiates with insurance carriers and health plans to purchase and administer the provisions of healthcare to public employees. Its plan options include coverage through Health Maintenance Organizations (HMOs), Exclusive Provider Organizations (EPOs), Preferred

Provider Organizations (PPOs), fully funded insurance plans, and self-insured plans. Each of these different vehicles falls within different, sometimes multiple regulatory frameworks. DMHC (Knox-Keene) regulates CalPERS' HMO and EPO plans and CDI regulates CalPERS' fully insured PPO plans. While ERISA does not technically regulate CalPERS' self-insured PPO plans, the plans generally adhere to ERISA practices (such as compliance with state insurance regulations). Additionally, CalPERS sets minimum plan standards and minimum coverage benefits that generally exceed regulatory requirements.

Under existing law, CalPERS administers three employee association plans for the California Association of Highway Patrolmen (CAHP), the Peace Officers Research Association of California (PORAC), and the California Correctional Peace Officers Association (CCPOA) respectively. These plans limit enrollment to their respective employee association membership. The associations develop their health plan benefit design and premiums and provide the information to CalPERS, which adopts pro forma the design and premiums at the same time it adopts the CalPERS plans. The association plan trustees are responsible for ensuring that their premiums and benefit changes are appropriate and that their reserve funds are adequate for their continued operations. Nevertheless, CalPERS indicates that these plans are subject to respective state and federal regulation since one is an HMO (Knox-Keene), one is a fully insured PPO (CDI), and one is a self-insured PPO not provided by the state and thus not exempt from ERISA (CDI or ERISA). Thus, any change to Knox-Keene and the Insurance Code should be sufficient to affect benefit coverage in the Association plans.

California Association of Highway Patrolmen (CAHP) Plan

Of the three employee association plans, the CAHP plan is the only self-insured PPO plan according to CalPERS. Thus, it retains the greatest flexibility in structuring its plan benefits, rating methods, and shared costs requirements. The bill's prohibition on CalPERS from approving a plan not in compliance with the bill's contraceptive coverage mandates could limit this flexibility. It is unclear though that the language is sufficient to override the existing mandate that CalPERS adopt CAHP's plan design as presented to CalPERS.

State Employee Access to Contraceptive Benefit Coverage

The bill's sponsors report anecdotal evidence that some state self-insured PPO plans have denied employees access to mandated contraceptive benefits with no cost sharing and thus, the bill is necessary to ensure that state employees have access to the required contraceptive benefit coverage. The committee notes that all state employees have access to state mandated contraceptive benefits through CalPERS' HMO, EPO, and fully insured PPO plans. It is not clear that any CalPERS or employee association self-insured PPO plan does not comply with the contraceptive benefit mandates but it is clear that every state employee eligible for those plans is also eligible for CalPERS plans that DMHC and CDI specifically regulate. Thus, it is erroneous to say that some state employees do not have access to these benefits.

University of California

This bill prohibits UC from approving a health plan contract for employees that does not comply with its contraceptive benefit mandates. UC operates self-insured health plans for employees and also for its student health plans, which are exempt from federal regulation. It is unclear how this bill would affect UC health plans.

The California Constitution gives the UC Regents "full powers of organization and government, subject only to such legislative control as may be necessary to insure the security of its funds and compliance with the terms of the endowments of the university and such competitive bidding procedures as may be made applicable to the university by statute for the letting of construction contracts, sales of real property, and purchasing of materials, goods, and services."

It is unclear whether there is a sufficient nexus between this bill's enhanced contraceptive benefit mandates and the regulation of competitive bidding contracts to overcome UC's general insulation from Legislative control. Although ensuring seamless access to contraceptive benefits without cost sharing seems to qualify as a matter of statewide concern and argues for Legislative authority over UC, the mandate touches on exclusively university affairs with respect to faculty employment and university employee benefits.

This bill may affect UC's self-insured student health plans. Although the language specifically references health plans "for employees" many UC students are also UC employees. Additionally, it is unclear whether the UC student health plan is part of the same self-insured health plan for UC employees.

3. Need for this bill?

According to the Author,

> The COVID-19 public health emergency has also 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 percent of Black women and 45 percent of Latinas, compared to 29 percent of white women, now face difficulties accessing birth control as a result of the pandemic. 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%).
>
> 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. Birth control is essential health care and all Californians should be able to equally access the method that is right for them, regardless of their income, insurance status or where they work. After four years of attacks on reproductive health during the Trump administration, California can and must advance pro-active solutions to ensure that Californians get the birth control they want, when they need it, without delay.

4. Proponent Arguments

According to the sponsors,

> 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.

According to the National Council of Jewish Women Los Angeles,

> We express our support for SB 523 – the Contraceptive Equity Act of 2021. This measure seeks to expand and modernize birth control access in California, regardless of an individual's gender, insurance coverage status or place of employment.

According to the Religious Coalition for Reproductive Choice of California,

> A report by the Guttmacher Institute revealed that 38 percent of Black women and 45 percent of Latinas, compared to 29 percent of white women, now face difficulties accessing birth control as a result of the pandemic. 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%).
>
> 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

5. Opponent Arguments:

The California Catholic Conference requests that the Legislature amend the bill to include a plan, issuer, or third party administrator that provides or arranges coverage for religious employers within the statute's definition of "religious employer" for purposes of being exempt from the mandate.

6. Double Referral:

This bill has also referred to the Senate Health committee for hearing.

7. Prior Legislation:

SB 999 (Pavley, Chapter 499, Statutes of 2016) 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.

SB 1053 (Mitchell, Chapter 576, Statutes of 2014) requires, effective January 1, 2016, most health plans and insurers to cover a variety of FDA-approved contraceptive drugs, devices, and products for women, as well as related counseling and follow-up services and voluntary sterilization procedures. The law also prohibits cost-sharing, restrictions, or delays in the provision of covered services, but allows cost-sharing and utilization management procedures if a therapeutic equivalent drug or device is offered by the plan with no cost sharing.

SUPPORT

Essential Access Health (Co-Sponsor)
NARAL Pro-Choice California (Co-Sponsor)
National Health Law Program (Co-Sponsor)
Access Reproductive Justice
American Association of University Women California

American College of Obstetricians and Gynecologists District IX
Business & Professional Women of Nevada County
CaliforniaHealth+ Advocates
California Nurse-Midwives Association
Citizens for Choice
Courage California
End Hep C SF
End the Epidemics
Los Angeles LGBT Center
National Association of Social Workers, California Chapter
National Center for Youth Law
National Council of Jewish Women
Plan C
Planned Parenthood Affiliates of California
Religious Coalition for Reproductive Choice of California

OPPOSITION

California Catholic Conference (Oppose unless Amended)

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