SENATE COMMITTEE ON HEALTH
Senator Dr. Richard Pan, Chair

BILL NO: SB 523
AUTHOR: Leyva
VERSION: April 19, 2021
HEARING DATE: April 28, 2021
CONSULTANT: Teri Boughton

SUBJECT: Health care coverage: contraceptives

SUMMARY: 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, the University of California, the California State University, and plans directly operated by a bona fide public or private institution of higher learning to comply with the Act. Expands contraceptive coverage to include coverage through out-of-network pharmacy and retail settings and establishes specified limitations on employers with respect to an employee's reproductive decision making.

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) Exempts from the Knox-Keene Act a plan directly operated by a bona fide public or private institution of higher learning which directly provides health care services only to its students, faculty, staff, administration, and their respective dependents. [HSC § 1343]

3) 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]

4) Requires health plans and insurers, at a minimum to provide coverage without cost-sharing requirements for several services including, but not limited to evidence-based items or services that have in effect a rating of "A" or "B in the recommendations of the US Preventive Services Task Force and immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC). [HSC §1367.002 and INS §10112.2]

5) Requires a group and individual health plan contract and except for specialized health plan contracts, and individual or group policies of disability insurance that provides coverage for outpatient prescription drug benefits to include coverage for a variety of federal Food and Drug Administration (FDA)-approved prescription contraceptive methods designated by the plan or policy. Requires benefits for an enrollee to be the same for an enrollee's covered spouse and covered nonspouse dependents. [HSC §1367.25 and INS §10123.196]

6) 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]

7) Prohibits a health plan, except a grandfathered plan, and a group or individual policy of disability insurance, except for a specialized health insurance policy, from imposing cost sharing with respect to 5) and 6) above. Allows a plan or disability insurer to cover only one therapeutic equivalent of a contraceptive drug, device, or product unless it is determined medically inadvisable by the enrollee's or insured's provider. [HSC §1367.25 and §10123.196]

8) 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]

7) Defines "religious employer" as a nonprofit organization as described in the Internal Revenue Code for which the inculcation of religious values is its purpose, and it primarily employs and serves persons who share its religious tenets. [HSC §1367.25 and §10123.196]

8) Establishes the Public Employees' Hospital and Medical Care Act, administered by the Public Employees Retirement System board of directors (CalPERS) with the purpose of providing health plan benefits similar to private industry and promoting and preserving public employee health. [GOV § 22750, et. seq.]

9) Establishes contracting requirements for the University of California (UC), as specified. [PCC §10500 – 10506]

This bill:

1) Prohibits, commencing January 1, 2022, the CalPERS board, UC, and the California State University 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, and, reimburse enrollees and insureds for out-of-pocket costs for OTC birth control methods purchased at any out-of-network pharmacy or retailer in California without medical management restrictions.

5) Permits a health plan or insurer to limit the frequency and define quantities with which the coverage required under this bill is provided.

6) Requires coverage for clinical services related to the provision or use of contraception, including consultations, referrals, examinations, procedures, ultrasound, and anesthesia.

7) Exempts a qualifying health plan and disability insurer for a health savings account (HSA), but requires the carrier to establish the plan's cost-sharing for the coverage required pursuant to this bill at 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 (IRS) laws and regulations.

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

9) 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.

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

11) 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.

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

13) 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.

14) 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.

15) 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.

16) 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.

17) 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.

18) Requires any contract or agreement, express or implied, made by an employee to waive the benefits of 16) and 17) to be null and void.

19) Requires an employer, that requires compliance with an employee handbook, to include in the handbook notice of the employee rights and remedies under 16), 17), and 18) above.

20) States that the rights and remedies conferred by 16) - 19) above 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, and 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.

21) Finds that the legislature must take action to ensure that all Californians have equitable access to preventive contraceptive care, and 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. The Legislature intends for the relevant California departments and agencies to work in concert to ensure compliance with these provisions.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *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.

2) *Preventive services mandate.* The California Health Benefits Review Program (CHBRP) points out that the ACA requires that nongrandfathered group and individual health insurance plans and policies to cover certain preventive services without cost sharing when delivered by in-network providers and as soon as 12 months after a recommendation appears in the Health Resources and Services Administration (HRSA)-supported health plan coverage

guidelines for women's preventive services. Women's preventive care benefits under the HRSA guidelines include the full range of FDA-approved female-controlled contraceptives to prevent unintended pregnancy and improve birth outcomes, as prescribed by a health care provider. The guidelines also recommend coverage for patient education and counseling for women of reproductive capacity, if prescribed by a health care provider. There are currently 18 FDA-approved contraceptive methods for women, including:

a) Sterilization surgery for women;
b) Surgical sterilization via implant for women;
c) Implantable rods;
d) Copper intrauterine devices;
e) Intrauterine devices with progestin (all durations and doses);
f) The shot or injection;
g) Oral contraceptives — combined pill;
h) Oral contraceptives — progestin only;
i) Oral contraceptives — extended or continuous use;
j) The contraceptive patch;
k) Vaginal contraceptive rings;
l) Diaphragms;
m) Contraceptive sponges;
n) Cervical caps;
o) Female condoms;
p) Spermicides;
q) Emergency Contraceptives (EC) (levonorgestrel); and,
r) EC (ulipristal acetate).

Health plans and policies must cover at least one form of contraception in each of these methods without cost sharing. It should be noted that some of these contraceptives are available OTC, including female condoms, spermicides, and contraceptive sponges; however, they are only required to be covered if prescribed by a health care provider. There is no federal mandate to cover male-controlled contraceptive methods, including male condoms and sterilization procedures (vasectomies). Health plans and policies may use reasonable medical management techniques on contraception coverage to control costs and promote efficient delivery of care, including the imposition of cost sharing. For example, plans and policies may discourage brand-name pharmacy items over generic ones through cost-sharing. However, plans and policies must accommodate any individual for whom a particular drug (generic or brand name) would be medically inappropriate, as determined by the individual's health care provider, by having a mechanism for waiving cost sharing for the physician-recommended product based on medical necessity.

3) *EHBs*. Nongrandfathered plans and policies sold in the individual and small-group markets are required to meet a minimum standard of benefits as defined by the ACA as EHBs. In California, EHBs are related to the benefit coverage available in the Kaiser Foundation Health Plan Small Group Health Maintenance Organization (HMO) 30 plan, the state's benchmark plan for federal EHBs. CHBRP estimates that approximately four million Californians (10%) have insurance coverage subject to EHBs in 2021. States may require plans and policies to offer benefits that exceed EHBs. However, a state that chooses to do so must make payments to defray the cost of those additionally mandated benefits, either by paying the purchaser directly or by paying the qualified health plan (QHP). Health plans and policies sold outside of the health insurance marketplaces are not subject to this requirement. State rules related to provider types, cost sharing, or reimbursement methods would not meet the definition of state benefit mandates that could exceed 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. This would appear to trigger the ACA requirement that the state defray the cost of additional benefit coverage for enrollees in QHPs in Covered California. CHBRP estimated several scenarios regarding the cost to the state, should this bill be judged to exceed EHBs. Impacts would vary by market segment (and by market segment enrollment). In scenario 1, the full estimated cost would likely range between $395,000 in the CDI-regulated individual market and $20,072,000 in the DMHC-regulated individual market (this does not include coverage for vasectomies because it is already required under EHB but it does include estimates of not imposing cost sharing for vasectomies). In scenario 2, with the full estimated cost with cost offsets, the impacts would vary from -$7,867,000 in the DMHC-regulated individual market to -$125,000 in the CDI-regulated individual market. In scenario 3, with baseline coverage offset, the impacts would range from $395,000 in the CDI-regulated small-group market and $20,072,000 in the DMHC-regulated individual market. Scenario 3 is the marginal impact of the benefit, excluding the impact of people who currently have coverage. CHBRP assumed no coverage for OTC contraceptives at baseline, so the marginal impact is equal to the total impact.

4) *CHBRP analysis.* AB 1996 (Thomson, Chapter 795, Statutes of 2002) requests 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, and reviewed this bill. Key findings include:

   a) CHBRP indicates this bill impacts coverage, costs, and related terms and conditions for six contraceptive types, including condoms (male and female), sponges, spermicides, levonorgestrel (EC), and vasectomy.

   b) *Coverage impacts and enrollees covered*. This bill would apply to the health insurance of approximately 21.9 million enrollees (55.7% of all Californians). This represents 100% of Californians who will have health insurance regulated by the state that may be subject to any state health benefit mandate law, which includes health insurance regulated by the DMHC or the CDI. CHBRP estimates at baseline 0% of enrollees have coverage of nonprescription OTC contraceptives, and 100% have coverage with some cost sharing, depending on the plan or policy, for vasectomies and related clinical services.

   c) *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.

d) *Utilization*. 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. CHBRP estimates 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 at baseline, 18,755 individuals use nonprescription OTC female barrier contraceptives (e.g., sponge, female condom, and spermicide). Postmandate, 19,513 individuals would use female nonprescription OTC contraceptives, an increase of 4.05%. At baseline, 106,492 individuals use ECs. Postmandate, 110,794 individuals would use ECs, an increase of 4.04%. 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%. 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%

e) *Medi-Cal*. For beneficiaries under Medi-Cal managed care plans, all contraception that is impacted by this bill is fully covered without cost sharing either under the Medi-Cal program or the California Family Planning, Access, Care, and Treatment (Family PACT) Program, or CHBRP assumes would be covered under the pharmacy benefit and therefore "carved out" of care provided by Medi-Cal managed care plans.

f) *Impact on expenditures*. 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 STIs as a result of this bill. 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. 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 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.

g) *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.

5) *Triple referral*. This bill has been triple referred. It passed the Labor, Public Employment and Retirement Committee on April 5, 2021 on a vote of 4-0.

6) *Related legislation*. SB 245 (Gonzalez) prohibits cost-sharing, prior authorization and annual or lifetime limits on all abortion services, including follow-up services, to an enrollee or insured. *SB 245 passed the Senate Health Committee with at 8-2 vote on April 7, 2021.*

7) *Prior legislation*. SB 999 (Pavley, Chapter 499, Statutes of 2016) authorizes a pharmacist to dispense a 12-month supply of FDA-approved, self-administered hormonal contraceptives, requires insurance to cover the cost, and prohibits a health plan or health insurer from imposing utilization controls or other forms of medical management.

   SB 1053 (Mitchell, Chapter 576, Statutes of 2014) requires 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. 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.

   SB 493 (Hernandez, Chapter 469, Statutes of 2013) expands the scope of practice of a pharmacist to recognize an "advanced practice pharmacist;" permits pharmacists to furnish certain hormonal contraceptives, nicotine replacement products, and prescription medications for travel, as specified; and authorizes pharmacists to independently initiate and administer certain vaccines and treatments for severe allergic reactions.

8) *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. 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. California Academy of Family Physicians writes that they fully support their patients' ability to access affordable contraception and birth control.

9) *Oppose unless amended*. The California Catholic Conference requests amendments to existing law to replace the existing definition of religious employer with the following:

(1) For purposes of this section, a "religious employer" is a church, an integrated auxiliary of a church, a convention or association of churches, a religious order, or a nonprofit organization, which objects, based on sincerely held religious beliefs, to its establishing, maintaining, providing, offering, or arranging for (as applicable):

(A) Coverage or payments for some or all contraceptive services; or
(B) A plan, issuer, or third party administrator that provides or arranges such coverage or payments.

11) *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. These bills will lead to higher premiums, harming affordability and access for small businesses and individual market consumers. 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.

12) *Senate Judiciary Committee policy comment*. This bill touches on various issues within the jurisdiction of the Senate Judiciary Committee, most prominently the issues of discrimination and the interplay between the First Amendment and neutral insurance requirements. With respect to the issue of discrimination, this bill amends the Labor Code to prohibit an employer from taking an adverse employment action against an employee based on that employee's reproductive health care decisions. New York and the District of Columbia already prohibit employment discrimination based on reproductive health care decisions (D.C. Code, § 2-1401.5; NY CLS Labor, § 203-e); and protecting Californians from adverse employment actions arising from their most private and personal health care choices, which have nothing to do with their performance on the job, appears consistent with the state's existing antidiscrimination laws. To the extent that a religious employer has a religious

objection to birth control, the ministerial exception would permit the religious employer to impose different standards on its ministers and similar employees (*Hope International University v. Superior Court* (2004) 119 Cal.App.4th 719, 734). The bill also provides express exemptions for religious employers that do not want to provide birth control to their employees, and the requirements for institutions of higher learning appear to be subject to those religiously based exemptions. The bill therefore does not appear to raise any significant First Amendment concerns.

13) *Amendments.* The author requests the committee adopt the following amendments:

a) Delete intent language related to condoms;
b) Delete a requirement that health plans and insurers reimburse enrollees/insureds for out-of-pocket costs for OTC birth control methods purchased at any out-of-network pharmacy or retailer in California without medical management restrictions;
c) Delete authority for plans and insurers to limit the frequency and define quantities with which the coverage required under this bill is provided;
d) Delete a provision that prohibits a religious employer that invokes the exemption under the law from discriminating, firing, or enforcing other workplace punishment against an employee based on the employer's decision to independently obtain contraceptive coverage, care, or prescriptions outside of the employer-based plan;
e) State that "OTC FDA-approved contraceptive drugs, devices, and products" and "OTC birth control methods" are limited to those included as EHBs, as specified;
f) Prohibit a health plan and insurer from imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on vasectomy coverage provided under EHBs, except for a grandfathered health plan or insurer, or a qualifying health plan for a HSA. For HSA compatible coverage, require carriers to establish cost sharing necessary to comply with the IRS laws and regulations, as specified;
g) Extend requirements of this bill and the contraceptive mandate to vasectomy coverage, as specified; and,
h) Permit, instead of requires, DMHC and CDI to promulgate regulations, as specified.

SUPPORT AND OPPOSITION:

Support: Essential Access Health (co-sponsor)
NARAL Pro-Choice California (co-sponsor)
National Health Law Program (co-sponsor)
Access Reproductive Justice
ACLU California
American Association of University Women- California
American College of Obstetricians and Gynecologists District IX
Bienestar Human Services
Business & Professional Women of Nevada County
California Academy of Family Physicians
California Black Health Network
California Faculty Association
California Latinas for Reproductive Justice
California Nurse-Midwives Association
California Women's Law Center
California Health+ Advocates
Children's Hospital Los Angeles
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 Los Angeles
Plan C
Planned Parenthood Affiliates of California
Religious Coalition for Reproductive Choice California
The Los Angeles Trust for Children's Health
Training in Early Abortion for Comprehensive Healthcare
Women's Foundation California
Women's Health Specialists

Oppose: America's Health Insurance Plans
Association of California Life and Health Insurance Companies
California Association of Health Plans
California Catholic Conference (unless amended)

-- END --